MARICOPA COUNTY

CIGNA HealthCare of Arizona, Inc.

Private Practice Plan

Point-of-Service

This document explains your Point-of-Service product. Your in-network benefits are provided by CIGNA HealthCare of Arizona, Inc. and are explained in the Group Service Agreement portion of this document. Your out-of-network benefits are provided by Connecticut General Life Insurance Company and are explained in the Out-of-Network portion of this document.

This document printed on August 30, 2001, takes the place of any documents previously issued to you which described your benefits.

Thank you for choosing CIGNA HealthCare!

Here is your guide to getting the most from your health care plan.

It outlines the important benefits of belonging to a CIGNA HealthCare plan,

tells you how to use those benefits wisely and

should answer most of your questions.

Please keep it for reference.

If you can't find the information that you need,

call Member Services at

the toll-free number on your CIGNA HealthCare ID card.

Or visit our web site, www.cigna.com.

We're here to help!

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Out-of-Network Table of Contents

The sections referenced within this Table of Contents describe your out-of-network benefits, which are underwritten by Connecticut General Life Insurance Company.

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CIGNA HealthCare Handbook

Your Benefit Plan

Your plan provides convenient, low-cost coverage in the CIGNA HealthCare of Arizona, Inc. network... plus the option, provided through a plan with Connecticut General Life Insurance Company, to go out of network when you want to.

You pay just a small out-of-pocket fee (copayment) for each in-network visit or service you use.

You may go out of network to see any doctor of your choice without a referral from your primary care physician, and still be covered, though your cost will be higher.

Two Important Reminders

1. *Carry your member ID card at all times.*
2. *Whenever you have a medical problem, contact your primary care physician first for advice, if you intend to stay in network.*

Any questions about your plan? Call Member Services.

You'll find the toll-free number on the back of your ID card.

Your Member ID Card

Keep it with you.

Show it before you receive care.

Show your card when you visit your primary care physician.

Show it when you're obtaining in-network services from:

A specialist

Hospital

*Pharmacy**

Lab

Any provider in the CIGNA HealthCare of Arizona, Inc. network

* *CIGNA HealthCare of Arizona, Inc. may not provide your Pharmacy coverage. Ask your Employer or call Member Services.*

Why It's Important

By showing your ID card, you:

Identify yourself as a CIGNA HealthCare of Arizona, Inc. member, which will minimize confusion and paperwork.

Make sure you'll be charged the correct amount.

Never lend your card. If it's ever lost or stolen, call Member Services immediately.

Your Primary Care Physician

Provides routine medical care, such as preventive checkups and treatment for illness.

Refers you to specialists when necessary and arranges for hospitalization when needed.

Your primary care physician coordinates your in-network health care. This doctor's responsibilities include:

Giving regular checkups to help keep you well

Providing treatment when you are ill

Ordering necessary lab work, X-rays, other tests

Referring you to a specialist

Arranging for hospitalization or outpatient treatment

Each member of your family may have his or her own primary care physician.

For Routine Health Care

Call your primary care physician for an appointment.

Should you have to cancel your appointment, notify the doctor at least 24 hours ahead. Some doctors charge for missed appointments.

Changing Your Primary Care Physician

You can change your primary care physician–should you want to. Call Member Services and we'll tell you how.

Changes are limited to one a month or three a year and are effective the first of the month following the date you notify us of your change. Or check with your employer regarding rules about changing your primary care physician.

Specialists

Before you see a specialist, make sure you have a referral from your PCP.

Check to be sure the specialist is a participant in the network.

When your primary care physician believes you have a medical condition that requires you to receive care from a specialist, your primary care physician will give you a referral – if you intend to stay in the network. You must have a referral from your primary care physician before you visit the specialist.

Making Appointments

When you call for an appointment, ask if the specialist is a participant in the CIGNA network.

If the specialist is not a CIGNA HealthCare of Arizona, Inc. participating provider, you may not be covered for services you receive from the specialist at in-network rates. Call Member Services to check on your coverage, or ask your primary care physician for another referral.

Limitations

The in-network specialist is authorized to provide only the services approved by the referral. Other services may not be covered.

The referral is good for a limited number of days. If the specialist says you'll need additional visits or another referral, the specialist should contact your primary care physician or CIGNA for authorization.

Check with Member Services to make sure the additional care will be covered.

OB/GYN

Under your plan, you can see an OB/GYN for covered obstetrical and gynecological services. This means that you do not have to obtain authorization from your primary care physician (PCP) for visits to the participating provider of your choice for pregnancy, well-woman gynecological exams, primary and preventive gynecological care and acute gynecological conditions.

You will still select your PCP from the designated list of internists, family or general practitioners.

When specialty care is needed, your PCP is still responsible for referring you to all specialists other than OB/GYNs.

If your PCP is part of a medical group that includes OB/GYNs, and if you are currently required to see specialists within that same medical group, you will need to visit an OB/GYN within that same medical group in order for services to be covered.

You pay only the standard office visit copayment for this exam.

There is also no need to obtain a referral from your primary care physician if your gynecologist recommends a screening mammogram during your annual well-woman exam. The procedure must be obtained at a participating facility.

Hospitalization

Your primary care physician arranges it.

Show your ID card when you are admitted.

A non-emergency hospital stay (other than a maternity admission) must be approved in advance by CIGNA HealthCare of Arizona, Inc. for in-network coverage.

Your primary care physician or authorized specialist will work with CIGNA to obtain authorization and arrange for your admission.

When hospital care is necessary, your doctor will arrange to have you admitted to a hospital that participates in the CIGNA HealthCare of Arizona, Inc. network.

When you arrive at the hospital, show your CIGNA HealthCare of Arizona, Inc. ID card at the admissions office.

Maternity hospital stays of 48 hours (96 hours for cesarean section births) do not require prior authorization.

Emergencies

Go to the nearest Emergency Room immediately.

Call your primary care physician as soon as possible.

Emergency care is covered 24 hours a day, 7 days a week, no matter where you are.

To ensure coverage for emergency care services, refer to your Group Service Agreement for further details.

Urgent Care

Call your primary care physician.

You are also covered for urgent care.

These are situations that require prompt medical attention–though they are not emergencies.

How to recognize urgent situations:

Symptoms occur unexpectedly.

They are severe.

You sense that delay could cause serious medical problems.

But the condition does not appear to be life-threatening.

Examples of urgent situations:

Severe sore throat

High temperature

Ear or eye infection

What to Do

In your home area, call your primary care physician.

The doctor may tell you:

What you can do at home

To come to the office

To go promptly to a participating urgent care center near you

To go to a hospital Emergency Room

If it's not an emergency, do not go directly to the Emergency Room. Call your primary care physician first.

Away from Home

Emergencies and Urgent Care are covered, even when you're away from home.

When you're traveling–away from your CIGNA network service area–you are still covered for emergencies or any serious illness or injury that requires urgent care.

Guidelines for Action

Although you're covered, you will be responsible for paying for emergency and urgent care treatment you receive out of your home area and then you will be reimbursed. You should:

Keep a copy of the bill.

Call Member Services when you get home and ask how to get reimbursed.

If you enter a hospital or require continuing care:

Call Member Services within 48 hours or as soon as possible, or have someone call for you.

CIGNA HealthCare of Arizona, Inc. will contact your primary care physician to arrange follow-up treatment if needed.

Member Services will tell you if there is a CIGNA HealthCare network in the city you're visiting and how to contact a participating provider.

Check your Group Service Agreement, Summary Plan Description, or insurance certificate for a more detailed explanation of your coverage.

Out-of-Network Benefits

You're still covered, but your costs will be higher.

Your out-of-network benefits will apply when:

You obtain care from a doctor who does not participate in the CIGNA HealthCare of Arizona, Inc. network

You go to a specialist without a referral from your primary care physician (unless it is a participating gynecologist you are seeing for your annual well-woman exam)

You enter a hospital for non-emergency treatment without going through your primary care physician

You receive outpatient service for conditions that are neither emergencies nor urgent care–without authorization from your primary care physician

Important Differences

Your out-of-network coverage has these differences and limitations:

Preventive care is not covered.

Your out-of-network coverage is only for treatment–not for periodic physical exams or immunizations.

You have to pay a deductible and coinsurance.

You'll have to pay for out-of-network medical services yourself until you reach the "deductible" amount specified in your Benefits Summary, Summary Plan Description, or insurance certificate. Then, you'll have to pay a percentage (called "coinsurance") of each eligible medical bill, as specified in your certificate.

You have to keep track of the out-of-network expenses you pay.

There is an out-of-pocket maximum for each covered individual and for the family as a whole. After that, all eligible charges will be covered 100 percent. Your deductible does not count toward your out-of-pocket maximum.

Services are covered up to the "reasonable and customary" amount.

In addition to your deductible and coinsurance, you will be responsible for any portion of a medical bill that goes beyond established "reasonable and customary" charges for your area.

Pre-existing conditions are not covered.

Any injury or illness for which you have been diagnosed, received treatment, or incurred expenses during the 90 days before your plan took effect is considered "pre-existing." You're not covered for such conditions unless you go for the first 90 days of your plan coverage without incurring expenses for the condition, or unless you've been covered by the plan at least 12 months. If you are covered under another plan (other than one issued in connection with a state high risk pool) to within 63 days of coverage under this plan, you will be given credit for the time you were covered under the prior plan.

However, you are covered for pre-existing conditions when you obtain treatment in the CIGNA network.

You have to submit claim forms.

Send in a claim every time you use an out-of-network service. Forms are available from your employer, or call Member Services.

Hospital Coverage Out-of-Network

To assure full benefits for a non-emergency hospital stay that's out-of-network, it must be approved in advance. Here's the procedure:

Call CIGNA Member Services seven to 10 days before scheduled admission. The phone number is on your ID card.

Have your CIGNA ID card handy. Give your ID number and the other information requested.

Ask for "pre-admission certification." Tell the facts of your upcoming hospitalization. Be prepared to give the full name, address, and telephone number of your doctor.

Your request will be reviewed by a registered nurse. You and your doctor will be notified quickly of the length of stay that has been approved.

If your request for hospitalization is not approved, CIGNA HealthCare of Arizona, Inc. will discuss the case with your doctor to reach an agreement as to appropriate treatment.

If you enter the hospital after certification is denied, you will have no coverage for that hospital stay.

If you enter the hospital before calling to request certification, you will not be covered for the first $500 of charges. That includes days spent in a hospital beyond an approved length of stay.

If your hospitalization request is approved, your hospitalization will be covered at the levels indicated in your plan for out-of-network benefits. (See your Benefits Summary, Summary Plan Description, or insurance certificate.)

Member Services

Member Services is available to answer your questions, address your concerns, and make sure you are satisfied with your health care plan. If English is not your preferred language, Member Services can arrange for a telephone interpreter to assist in answering your questions.

Call Member Services promptly if you:

Have questions

Change your name, address, phone number, marital status, or employment

Have a change in your family (adding or removing a dependent)

Also, let your employer know about any family change as soon as possible. It could affect your coverage.

Guidelines for Growing Families

Be sure to follow guidelines for enrolling new dependents such as a newborn baby, an adopted child, or a new spouse. There are specific periods of time in which you must enroll new dependents. Check with Member Services to find out what to do to ensure their coverage.

Check with your employer, too. Some employer groups have their own policies concerning the addition of dependents.

Duplicate Coverage

You cannot be reimbursed for more than the cost of any health care service you receive.

If you have duplicate coverage, you may have to take steps to avoid duplication of benefits.

Duplicate coverage can occur if:

Wife and husband are both employed and each enrolls the other and/or their dependent children in his and her employers' health plans.

Each family member will then have "primary" and "secondary" coverage. If CIGNA is providing secondary coverage, you may have to submit claim forms to your primary coverage carrier–even for visits to CIGNA HealthCare of Arizona, Inc. providers. See details in your Group Service Agreement, Summary Plan Description, or insurance certificate and instructions from your primary coverage carrier.

An injury is covered by other insurance, such as auto insurance or homeowner's. Check with Member Services for steps to take.

Please notify Member Services of any change in your duplicate coverage.

What to Do if You're No Longer Covered

Changes in employment, marital status, or age of a dependent can bring an end to coverage under your employer's group health plan. But you may be able to continue coverage or convert to another plan. Your Group Service Agreement, Summary Plan Description, or insurance certificate explains how.

Your Rights and Roles

CIGNA HealthCare of Arizona, Inc. is committed to providing personalized, quality and cost-effective care. As a CIGNA HealthCare of Arizona, Inc. member, you

have certain rights and roles and it is important that you fully understand them.

Your Rights

You have the right:

To be treated in a manner that respects your privacy and dignity as a person.

To receive assistance in a prompt, courteous and responsible manner.

To be provided with information about your health care benefits, any exclusions and limitations associated with the plan and any charges that you will be responsible for.

To confidential handling of all communications and medical information maintained at CIGNA HealthCare of Arizona, Inc., as provided by law and professional medical ethics. Your written permission will always be required for CIGNA HealthCare of Arizona, Inc.'s release of medical information, except when:

Clinical information is requested by health professionals for your care.

CIGNA HealthCare of Arizona, Inc. is legally obligated to release information.

CIGNA HealthCare of Arizona, Inc. prepares and releases information in the form of statistical summaries that do not identify individual participants.

Information is necessary to support or facilitate claims payment, utilization management or quality management.

To be informed by your treating health professional of your diagnosis, prognosis, and plan of treatment in terms you understand.

To be informed by your treating health professional about any appropriate or medically necessary treatment you may receive, regardless of cost or benefit coverage. Your treating health professional will request your consent for all treatment, unless there is an emergency and your life and health are in serious danger.

To refuse treatment and be advised of the possible consequences of your decision by your treating health professional. We encourage you to discuss your objections with your primary care physician. He or she will advise and discuss alternative treatment plans with you, but you will have the final decision.

To be provided with a listing of participating Primary Care Physicians and Obstetric/Gynecology providers.

To select a Primary Care Physician (PCP) and to change your PCP for any reason.

To express a complaint about CIGNA HealthCare of Arizona, Inc. and/or the quality of care you have received and to receive a response in a timely manner.

To initiate the grievance procedure if you are not satisfied with CIGNA HealthCare of Arizona, Inc.'s decision regarding your complaint.

Your Roles

All participants have a role in learning how the CIGNA HealthCare of Arizona, Inc. system works by carefully studying and referring to your benefit documents. Please call CIGNA HealthCare of Arizona, Inc.'s Member Services Department when you have questions or concerns about the plan.

Your role is:

To fully understand the information provided by CIGNA HealthCare of Arizona, Inc. regarding your health benefits.

To know the proper use of CIGNA HealthCare of Arizona, Inc.'s services.

To present your ID card prior to receiving services.

To consult your Primary Care Physician for his/her direction prior to receiving medical care (except in life-threatening situations).

To keep scheduled appointments and notify the physician's office promptly if you will be delayed or are unable to keep an appointment.

To pay all charges, if any, for missed appointments and non-covered services.

To work with your Primary Care Physician to establish a continuous and satisfactory relationship with your Primary Care Physician, and to schedule a "new patient" appointment with any new CIGNA PCP.

To ask questions of your physician and seek clarifications until you fully understand the care you are receiving.

To follow the advice of your Primary Care Physician and consider the likely consequences when you refuse to comply.

To provide honest and complete information to those providing care.

To know what medication you are taking, why you are taking it, and the proper way to take it.

To express your opinions, concerns, or complaints in a constructive manner to the appropriate people within CIGNA HealthCare of Arizona, Inc. or the provider network.

To make sure that CIGNA HealthCare of Arizona, Inc. is notified in a timely manner of any changes in family size, address, phone number, or membership status.

To make premium payments on time if they are not paid directly by your employer.

To pay all applicable copayments at the time service is rendered.

For Further Information

Get to know your CIGNA plan.

A great deal of information is available to you–some of which you previously received, and some of which is enclosed–including:

Your Guide to Good Health It has your Directory of Providers and a lot more. You received a copy before enrolling.

The Benefits Summary The brochure you received before enrolling. It has the highlights of your plan, including coverage and costs to you.

Group Service Agreement, Summary Plan Description, or insurance certificate A more complete explanation of your coverage.

Member Services Our knowledgeable advisors are on hand to answer your questions. See your ID card for the toll-free number.

Group Service Agreement

SECTION I: Introduction

This Agreement is entered into between HEALTHPLAN and the GROUP which is named and identified on the Face Sheet and which is acting on its own behalf and on behalf of its eligible employees and their eligible family members who enroll pursuant to this Agreement. Masculine terms used in the Agreement shall include the feminine.

SECTION II: Interpretation of Agreement

Direct-Service Nature of Program

In order to provide the advantages of an integrated and coordinated system of health care, HEALTHPLAN operates on a direct-service rather than an indemnity basis. The interpretation of the Agreement shall be guided by the direct-service nature of HEALTHPLAN's health care service program.

Inclusion of Group-Specific Eligibility Criteria

Membership eligibility criteria are generally described in the "Eligibility" Section of the Agreement. GROUP may have established its own specific membership eligibility criteria. Those criteria, as stated in the Face Sheet of the Agreement, are incorporated by reference and are part of this Agreement. Members should contact GROUP to confirm applicable eligibility criteria. Upon request from Members, HEALTHPLAN will provide a summary of group-specific eligibility criteria contained in the applicable Face Sheet.

SECTION III: Role of the Primary Care Physician

Establishment of the Physician-Patient Relationship

By enrolling in the HEALTHPLAN, Members choose to have services and benefits under the "Services and Benefits" Section provided or arranged by a Primary Care Physician. The Primary Care Physician maintains the physician-patient relationship with Members who select him as their Primary Care Physician. The Primary Care Physician is responsible to the HEALTHPLAN for providing and/or coordinating Medical Services and Hospital Services for overall health care needs of such Members.

Selection of Primary Care Physician

At the time of enrollment, each Subscriber shall designate one Primary Care Physician for himself and each of his Dependents. The Subscriber may designate a different Primary Care Physician for himself and each of his Dependents. HEALTHPLAN will assign a Primary Care Physician when Member does not select a Primary Care Physician, or when the selected Primary Care Physician is unable to render services under this Agreement. Once the Primary Care Physician is selected, the physician will be notified of the selection.

In the event a Member wishes to change the designation of his Primary Care Physician, he must contact HEALTHPLAN and follow its instructions. HEALTHPLAN reserves the right to limit the number of such changes to not more than once in any calendar month or three times in any calendar year. Such change will be effective on the first day of the month following the month in which HEALTHPLAN completes the processing of the change request.

In the event that a Member's Primary Care Physician ceases to provide care under the Agreement, HEALTHPLAN will designate a new Primary Care Physician, and the Member will be given the opportunity to accept that physician or choose another Primary Care Physician.

Disagreement with Recommended Treatment

A Member enrolls in the HEALTHPLAN with the understanding that his Primary Care Physician is responsible for determining the treatment appropriate to the Member's care. A Member who uses non-HEALTHPLAN sources of care because of a disagreement with the Primary Care Physician as to the medical need or propriety of such care, does so with the full understanding that the HEALTHPLAN has no obligation for the cost or legal liability for the outcome of such care.

Standing Referral to Specialist

You may apply for a standing referral to a provider other than your PCP when all of the following conditions apply:

1. You are a covered member of the Healthplan;
2. You have a disease or condition that is life threatening;
3. Your PCP in conjunction with network specialist determines that your care requires another provider's expertise;
4. Your PCP determines that your disease or condition will require ongoing medical care for an extended period of time;
5. The standing referral is made by your PCP to a network specialist who will be responsible for providing and coordinating your specialty care; and
6. The network specialist is authorized by the Healthplan to provide the services under the standing referral.

We may limit the number of visits and time period for which you may receive a standing referral. If you receive a standing referral or any other referral from your PCP, that referral remains in effect even if the PCP leaves the Healthplan's network. If the treating specialist leaves the Healthplan's network or you cease to be a covered member, the standing referral expires.

Transition Care

There may be instances in which your PCP becomes unaffiliated with the Healthplan's network of Participating Providers. In such cases, you will be notified and provided assistance in selecting a new PCP.

However, in special circumstances, you may be able to continue seeing your doctor, even though he or she is no longer affiliated with the Healthplan. If you are a new Member, upon written request to the Healthplan, you may continue an active course of treatment with your current health care provider during a transitional period after the effective date of enrollment if both of the following apply:

1. You have a life threatening disease or condition, in which case the transitional period will not be more than thirty (30) days after the effective date of enrollment;
2. Entered the third trimester of pregnancy on the effective date of enrollment, in which case the transitional period includes the delivery and any care up to six weeks after the delivery that is related to the delivery.

If you have been receiving care and a continued course of covered treatment is Medically Necessary, you may be eligible to receive "transitional care" from the non-participating provider for up to thirty (30) days. You may also be eligible to receive transitional care if you are in your second trimester of pregnancy. In this case, transitional care may continue through your delivery and post-partum care. Such transitional care must be approved in advance by the Healthplan, and your doctor must agree to accept our reimbursement rate and to abide by the Healthplan's policies and procedures and quality assurance requirements. There may be additional circumstances where continued care by a provider no longer participating in the Healthplan's network will not be available, such as when the provider loses his license to practice or retires.

If you are a new Member whose health care provider is not a member of the Healthplan's network and you (i) are receiving an on-going course of treatment for a life-threatening disease or condition, or a degenerative or disabling disease or condition, or (ii) have entered your second trimester of pregnancy as of the effective date of your enrollment, you may be eligible to receive continuity of care from that non-participating provider for a transitional period of up to (60) days, or the post partum period directly related to the delivery of your child. Such continuity of care must be approved in advance by the Healthplan, and your doctor must agree to accept our reimbursement rate and to abide by the Healthplan policies and procedures and quality assurance requirements. There may be additional circumstances where continued care by a provider no longer participating in the Healthplan's network will not be available, such as when the provider loses his/her license to practice or retires.

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SECTION IV: Definitions

As used in the Agreement the following words and phrases have the meanings shown and all masculine terms shall include the feminine:

Agreement

means the CIGNA HealthCare Group Service Agreement, the Face Sheet, the Schedule of

Copayments, any optional Riders and any other attachments described herein, the Enrollment Application of a Member, and any subsequent amendment or modification to any part of the Agreement.

Anniversary Date of Agreement

means the date written on the Face Sheet as the Anniversary Date.

Continuation Coverage

means the extension of coverage under this Agreement that may be offered to a Subscriber or Dependent as described in "Section XI: Continuation of Group Coverage."

Contract Year

means the twelve (12)-month period beginning at 12:01 a.m. on the first day of the initial term or any renewal term and ending at 12:01 a.m. on the next anniversary of that date.

Copayment

means the fee charged to a Member at the time of service for certain covered services and benefits (exclusive of Supplemental Services), in the amount set forth in the Schedule of Copayments.

Creditable Coverage

means, with respect to an individual, coverage of the individual under any of the following: a group health plan; individual or group health insurance coverage; Part A or Part B of Medicare; Medicaid (except coverage solely for pediatric vaccines); coverage for members of the armed forces and their dependents; a medical care program of the Indian Health Service; a State health benefits risk pool; the Federal Employees Health Benefits program; a health plan provided under the Peace Corps Act; a state, county or municipal public health plan; coverage provided under state or federal health continuation mandates (such as COBRA); an individual or group health conversion plan.

Days

means calendar days unless expressly stated otherwise.

Dependent

means those individuals in the Subscriber's family who meet the eligibility requirements of the "Dependent" provision of the "Eligibility" Section and are enrolled under the Agreement.

Emergency

means a condition for which Emergency Services are required, as defined in the "Emergency Services" provision of the "Services and Benefits" Section.

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Experimental, Investigational and Unproven Services

means medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the HEALTHPLAN Medical Director to be:

1. not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified by the United States Pharmacopeia Dispensing Information or the American Hospital Formulary Service;
2. the subject of review or approval by an Institutional Review Board for the proposed use;
3. the subject of an ongoing clinical trial that meets the definition of a phase I, II or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight; or
4. not demonstrated, through existing peer-reviewed literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Face Sheet

means a part of this Agreement which contains certain provisions affecting the relationship between HEALTHPLAN and GROUP and which may be made available to Members by GROUP.

Formulary

means a listing of drug products and in some instances, dosage forms, approved by HEALTHPLAN for coverage under the HEALTHPLAN prescription drug program. This list shall be subject to periodic review by HEALTHPLAN.

GROUP

means the employer, labor union, trust, association, partnership, department, or other organization which enters into the Agreement on its own behalf and for the Member. GROUP is a Party to the Agreement.

HEALTHPLAN

means the CIGNA HealthCare entity identified on the cover page of this Agreement, a health care services organization which is organized under the laws of the State of Arizona. HEALTHPLAN is a Party to the Agreement.

HEALTHPLAN Medical Director

means a Physician charged with the direction and management of Participating HEALTHPLAN Physicians or his designee.

Hospice Care Program

means a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families; a program that provides palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness; and a program for persons who have a Terminal Illness and for the families of those persons.

Hospice Care Services

means any services provided by: (a) a Participating Hospital, (b) a participating skilled nursing facility or a similar institution, (c) a participating home health care agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program, which is a participating Medicare-approved Hospice Care Program.

Hospice Facility

means a participating institution or part of it which primarily provides care for Terminally Ill patients; is a Medicare-approved hospice care facility; meets standards established by HEALTHPLAN; and fulfills all licensing requirements of the state or locality in which it operates.

Hospital Services

(except as limited or excluded by the Agreement) means services for registered bed patients or outpatients which are customarily provided by acute care hospitals and which are authorized by HEALTHPLAN as specified in the "Services and Benefits" Section.

Medical Services

(except as limited or excluded by the Agreement) means those professional services of Physicians or Other Participating Health Professionals, including medical, surgical, diagnostic, therapeutic, and preventive services authorized by HEALTHPLAN as specified in the "Services and Benefits" Section.

Medically Necessary/Medical Necessity

means health care services and supplies which are determined by the HEALTHPLAN Medical Director to be:

1. medically appropriate to meet the basic health needs of the Member;
2. consistent with the diagnosis of the condition;
3. consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by medical research;
4. required for purposes other than the comfort and convenience of the patient or their physician;
5. rendered in the least intensive setting that is appropriate for the delivery of health care; and
6. of demonstrated medical value.

A health care service is medically appropriate when:

1. the expected health benefit from a medical service is clinically significant and significantly exceeds the anticipated health risk;
2. the health care service is considered by the HEALTHPLAN Medical Director to be of clinical value and represents a superior service to other medical services (including no medical services); and
3. the potential benefit from the health care service may include, but is not limited to, improved functional capacity, prevention of complications, or palliative relief.

Member

means any Subscriber or any Dependent.

Membership Unit

means the group of individuals consisting of a Subscriber and his Dependents.

Mental Illness

means any disorder which impairs the behavior, emotional reaction or thought process of a person, regardless of medical origin. In determining benefits payable, charges made for the treatment of any physiological conditions related to a Mental Illness, or rehabilitation services for alcohol or drug abuse or

addiction, will not be considered to be charges made for treatment of a Mental Illness.

Other Participating Health Care Facility

means any facility other than a Participating Hospital or Hospice Facility which is operated by or has an agreement with HEALTHPLAN to render services to Members. Other Participating Health Care Facilities include, but are not limited to, licensed, skilled nursing facilities and rehabilitation hospitals.

Other Participating Health Professional

means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver Medical Services and who has an agreement with HEALTHPLAN to render services to Members.

Participating Hospital

means an institution licensed as an acute care hospital under the applicable state law, which has an agreement with HEALTHPLAN to provide Hospital Services to Members.

Participating Physician

means a Primary Care Physician or other Physician who has an agreement with HEALTHPLAN to provide Medical Services to Members.

Participating Provider

means Participating Hospitals, Participating Physicians, Other Participating Health Professionals, and Other Participating Health Care Facilities.

Physician

means an individual who is qualified to practice medicine under the applicable state law or a partnership or professional association of such persons and is a licensed Doctor of Medicine or Doctor of Osteopathy.

Prepayment Fee

means the sum of money paid periodically to HEALTHPLAN by GROUP in order for the Member to receive the services and benefits covered by the Agreement.

Prevailing Rate

means the usual fee which HEALTHPLAN's Participating Providers charge self-pay patients for services not covered under this Agreement.

Primary Care Physician

means a Physician engaged in general practice, family practice, internal medicine or pediatrics who, through an agreement with HEALTHPLAN, provides basic health services to and arranges specialized services for those Members who select him as their Primary Care Physician.

Rehabilitative Therapy

(except as limited or excluded by the Agreement) means treatment modalities which are part of a rehabilitation program, including physical therapy, speech therapy and occupational therapy.

Rider

means an addendum to this Agreement between GROUP and HEALTHPLAN.

Service Area

means the geographic area within the State of Arizona.

Subscriber

means an employee, or retiree of, or a participant in, GROUP who meets the eligibility requirements of the "Subscriber" provision of the "Eligibility" Section and enrolls under the Agreement.

Supplemental Charge

means a fee charged to a Member for a Supplemental Service rendered by HEALTHPLAN in the amount set forth in any attached Riders.

Supplemental Service

means a service which is not covered under the Agreement but which may be offered to GROUP in an attached Rider and provided by HEALTHPLAN to a Member for a Supplemental Charge.

Terminal Illness

means an illness of a Member which has been diagnosed by a Physician and for which the Member has a prognosis of six months or less to live.

SECTION V: Eligibility

Subscriber

To be eligible to enroll as a Subscriber, an individual must:

1. reside in the Service Area at least nine (9) months per Contract Year (except as otherwise agreed to between HEALTHPLAN and GROUP and indicated under "GROUP's ENROLLMENT/ELIGIBILITY RULES" on the Face Sheet); and
2. be an employee of, or participant in, GROUP; and
3. meet and continue to meet all eligibility requirements for participation in the health benefit program established by GROUP and indicated under "GROUP's ENROLLMENT/ELIGIBILITY RULES" on the Face Sheet; and
4. be enrolled in Medicare Part A (Hospital) and Part B (Medical) or Part B only if an individual is eligible for Medicare benefits and Medicare is primary payor for the individual's coverage as specified by applicable law; and
5. not be ineligible by reason of any of the provisions of the "Specific Causes for Ineligibility" Section.

Dependent

To be eligible to enroll as a Dependent, an individual who is not ineligible by reason of any of the "Specific Causes for Ineligibility" of this Section must be at the time of enrollment:

SPOUSE. The Subscriber's legal spouse who resides in the Service Area at least nine (9) months per Contract Year (except as otherwise agreed to between HEALTHPLAN and GROUP and indicated under "GROUP's ENROLLMENT/ELIGIBILITY RULES" on the Face Sheet).

If the spouse is eligible for Medicare benefits and Medicare is primary payor for the spouse's coverage as specified by applicable law, the spouse must be enrolled in Medicare Part A (Hospital) and Part B (Medical) or Part B only; or

CHILDREN. A natural child, adopted child, stepchild, a child supported by the Subscriber pursuant to a valid court order or a child for whom the Subscriber is the legal guardian, if the child:

1. is unmarried and legally dependent upon the Subscriber for support; and
2. a. has not attained his nineteenth (19th) birthday; or

   b. has not attained his twenty-third (23rd) birthday (or such later birthday as specified in the Face Sheet or an attached Rider) if a registered full-time student in regular attendance at an accredited secondary school, college or university; or

   c. is permanently and continuously incapable of self-sustaining support by reason of mental retardation or physical handicap existing prior to his nineteenth (19th) birthday, as determined by the HEALTHPLAN Medical Director. Proof of the child's condition and dependence must be submitted, by Subscriber or Member, to HEALTHPLAN within thirty-one (31) days after the date the child ceases to qualify under subsections a. or b. of this provision. During the next two (2)-year period HEALTHPLAN may, from time to time, require proof of the continuation of such condition and dependence. After that HEALTHPLAN may require proof no more than once a year; and
3. has enrolled in Medicare Part A (Hospital) and Part B (Medical) or Part B only if eligible for Medicare benefits and Medicare is primary payor for the child's coverage as specified by applicable law.

   NOTE: A child eligible to enroll as a Dependent under this Agreement who resides outside of the Service Area is entitled to receive, while outside the Service Area, only out-of-area emergency benefits under the "Emergency Services" provision of the "Services and Benefits" Section.

   No services or benefits under this Agreement will be extended to the grandchild of the Subscriber unless the grandchild meets the eligibility requirements of "Dependent" of this Section and is enrolled as a Dependent pursuant to the "Enrollment" Section.

Specific Causes for Ineligibility

An individual shall not be entitled to enroll as a Subscriber or Dependent if:

1. the individual was previously a Member of HEALTHPLAN or any other health plan which is a direct or indirect subsidiary of its parent company,

and his membership was terminated for cause as described in the "For Cause" provision of the "Termination of Member Coverage" Section; or

2. the individual has unpaid financial obligations to HEALTHPLAN or any other health plan which is a direct or indirect subsidiary of its parent company.

SECTION VI: Enrollment

Open Enrollment

An individual, who is eligible to enroll as a Subscriber or Dependent, may enroll by submitting to GROUP a completed HEALTHPLAN enrollment application during designated open enrollment periods established at least once a Contract Year by HEALTHPLAN and GROUP, ***provided that*** HEALTHPLAN is only required to consider such applications received by HEALTHPLAN during the open enrollment period or within fifteen (15) days thereafter. The effective date of coverage shall be determined under the "Effective Date of Coverage" Section.

Newly Eligible Outside of Open Enrollment Period

An individual, who newly attains eligibility as a Subscriber or a Dependent outside of the designated open enrollment periods, may enroll by submitting to GROUP a completed HEALTHPLAN enrollment application and any additional Prepayment Fees due, ***provided that*** HEALTHPLAN is only required to consider such applications received by HEALTHPLAN within thirty-one (31) days of the event creating eligibility. The effective date of coverage shall be determined under the "Effective Date of Coverage" Section. If these enrollment requirements are not met, the individual may be enrolled during the next designated open enrollment period.

Special Enrollment

Marriage

A Subscriber may submit to GROUP a HEALTHPLAN enrollment application and any applicable Prepayment Fees due for himself, his new Dependent Spouse and any other Dependents within thirty one (31) days after the date of marriage. If these requirements are not met, the Subscriber and/or Dependents may be enrolled during the next designated open enrollment period.

Birth of a Dependent Newborn Child

A Subscriber may submit to GROUP a HEALTHPLAN enrollment application and any applicable Prepayment Fees due for himself, his newborn child and any other Dependents prior to the birth of the newborn child or within thirty one (31) days after birth. If these requirements are not met, the Subscriber and/or Dependents may be enrolled during the next designated open enrollment period.

A newborn child who is born while this Agreement is being paid for at OTHER than a single rate shall have coverage effective as of the date of birth. While not a pre-condition to such coverage, a Subscriber shall submit to HEALTHPLAN through GROUP an enrollment application for the newborn child prior to the birth of the child or within thirty-one (31) days after birth. A newborn child who is born while this Agreement is being paid for at a single or two-party rate shall have coverage effective as of the date of birth, if prior to the birth or within thirty-one (31) days after birth, the Subscriber submits to HEALTHPLAN through GROUP an enrollment application and pays the additional Prepayment Fees due. If these requirements are not met, the newborn child may be enrolled during the next designated open enrollment period.

Adoption of a Dependent Child

A Subscriber may submit to GROUP a HEALTHPLAN enrollment application and any applicable Prepayment Fees due for himself, his newly adopted child (or child placed with him for adoption) and any other Dependents within thirty one (31) days after the child is adopted or placed for adoption.

A child who is legally adopted by or is placed with the Subscriber for adoption while this Agreement is being paid for at other than a single rate shall have coverage effective as of the date the child is placed with the Subscriber. While not a pre-condition to such coverage, a Subscriber shall submit to HEALTHPLAN through GROUP an enrollment application for the adopted child within thirty-one (31) days after the date of placement. If the child is placed with the Subscriber before the adoption process is completed, the Subscriber shall also

submit to HEALTHPLAN proof that the application and approval procedures for adoption pursuant to A.R.S. Section 8-105 or Section 8-108 have been completed. A child who is legally adopted by or is placed with the Subscriber for adoption while this Agreement is being paid for at a single rate shall have coverage effective as of the date the child is placed with the Subscriber if, within thirty-one (31) days after the date of placement, the Subscriber submits to HEALTHPLAN through GROUP an enrollment application and GROUP pays any additional Prepayment Fees due. If the child is placed with the Subscriber before the adoption process is completed, the Subscriber shall also submit to HEALTHPLAN proof that the application and approval procedures for adoption pursuant to A.R.S. Section 8-105 or Section 8-108 have been completed.

If these requirements are not met but the adoption is later completed, the adopted child may be enrolled during the next designated open enrollment period. If the adoption process is not completed and coverage has been provided to a child under this Agreement, the Subscriber shall pay HEALTHPLAN for all services and benefits provided to the child at Prevailing Rates.

Guardianship of a Dependent Child

Subscriber must apply for dependent coverage and so notify GROUP and HEALTHPLAN within thirty-one (31) days of the effective date of coverage for the child subject to guardianship, as determined under the "Effective Date of Coverage" Section. If these requirements are not met, the child may be enrolled during the next designated open enrollment period.

Court-Ordered Coverage of a Dependent Spouse or Child

If a court orders that coverage be provided for a Dependent spouse or child, that spouse or child will be eligible for enrollment within the thirty-one (31) days after the court order is issued, and the open enrollment requirements will be waived. If these provisions are not met, the spouse or child may be enrolled during the next designated open enrollment period.

Loss of Prior Coverage

A Subscriber who declines coverage for himself and/or his Dependents (including his spouse) during an open enrollment period because of other coverage may enroll for coverage under this Agreement outside of the designated open enrollment period if the Subscriber or Dependent loses the other coverage. HEALTHPLAN is only required to consider such applications if the Subscriber or Dependent: lost coverage under any group or individual health benefits plan due to the employee's termination of employment or eligibility; reduction in the employee's work hours; termination of the other plan's coverage; the death of the spouse, legal separation or divorce; termination of employer contributions toward coverage; or completion of the continuation period if the other coverage was provided under COBRA or similar state continuation law; and provided that the Subscriber submits to GROUP a completed HEALTHPLAN enrollment application and any applicable Prepayment Fees due, and received by HEALTHPLAN within thirty-one (31) days of the date the Subscriber or Dependent lost the other coverage. If these enrollment requirements are not met, the individual may be enrolled during the next designated open enrollment period.

Application

Subscribers shall fully and accurately complete and sign the enrollment application. False or misrepresented material information provided during any enrollment may in HEALTHPLAN's sole discretion cause coverage of a Subscriber and/or his Membership Unit to be null and void from inception.

Duplicate Enrollment

If a Member is eligible for more than one HEALTHPLAN membership and is enrolled in HEALTHPLAN more than once at any given time, the Member shall be entitled to only one set of benefits and services and is not entitled to duplicate coverage.

SECTION VII: Effective Date of Coverage

Open Enrollment

Subject to payment of applicable Prepayment Fees in accordance with the "Payments" Section of this Agreement and to the other provisions of this Agreement, coverage of a Subscriber or Dependent shall become effective at 12:01 a.m. on the first day of compliance with the eligibility requirements of GROUP and HEALTHPLAN except as set forth below.

A Subscriber or a Dependent confined to a hospital on the effective date of coverage, must notify HEALTHPLAN of the hospital confinement within forty-eight (48) hours of the effective date or as soon thereafter as reasonably possible. HEALTHPLAN reserves the right to assume direct management of the health care of such Member and to transfer such Member to the care of a Participating Provider when the HEALTHPLAN Medical Director determines it medically prudent to do so, in consultation with the attending physician. In the event a Member fails to notify HEALTHPLAN within the specified forty-eight (48)-hour period (or as soon thereafter as reasonably possible) or refuses to permit HEALTHPLAN to assume health care management or to be transferred to a Participating Hospital, HEALTHPLAN is not responsible for or obligated to pay expenses relating to the Medical and Hospital Services rendered during this period of hospitalization.

Newly Eligible Outside of Open Enrollment Period

The effective date of coverage of an individual who newly attains eligibility as a Subscriber or a Dependent outside of the designated open enrollment period shall be the date of the event creating eligibility, provided that the enrollment requirements of the "Newly Eligible Outside of Open Enrollment Period" provision of the "Enrollment" Section have been met.

Marriage

The effective date of coverage following marriage of the Subscriber shall be the date of the marriage, provided that the enrollment requirements of the "Special Enrollment" provision of the "Enrollment" Section have been met.

Newborn Child

The effective date of coverage following the birth of a child shall be the date of the newborn child's birth, provided that the enrollment requirements of the "Special Enrollment" provision of the "Enrollment" Section have been met.

Adopted Child/Guardianship/Court-Ordered Coverage

The effective date of coverage following the legal adoption of a child or placement of a child with a Subscriber for adoption shall be the moment of legal placement, provided that the enrollment requirements of the "Special Enrollment" provision of the "Enrollment" Section have been met.

The effective date of coverage of a child placed with a Subscriber for guardianship or of a spouse or child covered under a valid court order shall be the date that the court order is legally effective, provided that the enrollment requirements of the "Special Enrollment" provision of the "Enrollment" Section have been met.

Loss of Prior Coverage

The effective date of coverage of an individual who is eligible to enroll after losing prior coverage shall be the first day of the calendar month beginning after the date a completed HEALTHPLAN enrollment application and applicable Prepayment Fees are received by HEALTHPLAN, provided that the enrollment requirements of the "Special Enrollment" provision of the "Enrollment" Section have been met.

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SECTION VIII: Payments

GROUP Payments

Only Members for whom GROUP has submitted completed enrollment applications and paid the required Prepayment Fees to HEALTHPLAN shall be entitled to services and benefits during the designated period for which such payment has been made.

Member Payments

Members shall pay all Copayments and Supplemental Charges for services rendered. Copayments and

Supplemental Charges are subject to change from time to time. The Subscriber shall be liable for all Copayments and Supplemental Charges incurred by the Membership Unit. Failure to pay the required Copayments or Supplemental Charges is a basis for termination of a Membership Unit for cause.

There is a limit on the total amount of Copayments paid by a Membership Unit within a Contract Year. The limit is based upon the size of the Membership Unit and shall not exceed the amount stated in the Face Sheet of this Agreement. In no event will Copayments for a Subscriber or any of Subscriber's Dependents exceed, in any Contract Year, two hundred percent (200%) of the total annual premium cost which Subscriber or Dependent would be required to pay if he (or they) were enrolled under an option with no Copayments. In addition, in no event shall any Copayment charged under this Agreement exceed fifty percent (50%) of the total cost of providing any single service to Members. For a copy of the Face Sheet or for more specific information about the maximum Copayment amount, Members should contact GROUP. Upon request, HEALTHPLAN will also provide information about the Copayment limit.

When a Membership Unit has paid Copayments up to the amount of the Copayment limit, the Membership Unit shall not be required to pay Copayments for the remainder of the Contract Year. This limit applies to Copayments and does not include Supplemental Charges.

It shall be the responsibility of the Subscriber to maintain a record of Copayments which have been paid by the Membership Unit and to inform HEALTHPLAN when the amount of those Copayments reaches the limit.

SECTION IX: Termination of Member Coverage

For Cause

HEALTHPLAN may terminate coverage of a Member and/or his Membership Unit for cause upon sixty (60) days written notice for any of the following:

1. obtaining or attempting to obtain services or benefits for Member or others under this Agreement by means of false, misleading or fraudulent information, acts or omissions, including, but not limited to:
   a. false or misrepresented material information entered in the enrollment application or provided to GROUP or HEALTHPLAN;
   b. permitting a non-Member to use a membership card or to obtain services and benefits.
2. behavior which is, in the opinion of HEALTHPLAN, disruptive, unruly, abusive or uncooperative to the extent that the continued enrollment of Member seriously impairs HEALTHPLAN's ability to furnish services to the Member or other Members. Any termination of a Member's coverage under this Paragraph 2 will be in accordance with the applicable internal HEALTHPLAN appeals process and shall include a determination that the behavior for which the Member's coverage has been terminated is not the result of Mental Illness, health status, or utilization of services and benefits. In the event the coverage of a Subscriber is terminated under this Paragraph 2, coverage for enrolled Dependents will not be terminated, but will be continued in accordance with the terms of this Agreement.

By Reason of Ineligibility

Subject to the continuation and/or conversion rights under the "Conversion to Non-Group (Individual) Coverage" Section or the "Continuation of Group Coverage" Section of the Agreement, upon loss of eligibility coverage shall cease as follows:

1. Coverage of a Member shall cease upon loss of the Member's eligibility as defined in the "Subscriber" and "Dependent" provisions of the "Eligibility" Section in accordance with the rules set forth in the Face Sheet under the heading "Disenrollment."
2. Coverage of all Members within a Membership Unit shall cease upon loss of the Subscriber's eligibility as defined in the "Subscriber" provision of the "Eligibility" Section in accordance with the rules set forth in the Face Sheet under the heading "Disenrollment."
3. Coverage of a Dependent shall cease upon the death or divorce of the Subscriber, in accordance with the rules set forth in the Face Sheet under the heading "Disenrollment."

The termination of coverage for the reasons described in this "By Reason of Ineligibility" provision will be effective on the date the loss of eligibility occurs. On the effective date of termination of coverage, HEALTHPLAN shall have no further obligation to provide services and benefits to the Member whose coverage has been so terminated.

Certification of Coverage Upon Termination

A certificate of Group Health Plan Coverage will be provided:

a. when Member's coverage under the Agreement is terminated in accordance with the "For Cause" or "By Reason of Ineligibility" provisions or otherwise becomes covered under the "Continuation of Group Coverage" Section of the Agreement;

b. when Continuation Coverage is exhausted; and

c. if an individual makes a request no later than twenty-four (24) months after the date coverage under (a) or (b) described above ends.

The certificate of Group Health Plan Coverage will be issued by the HEALTHPLAN according to information provided by the GROUP or by a third party administrator designated by the GROUP.

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Termination of Agreement

1. **Termination on Notice**. The Agreement may be terminated without cause by GROUP upon sixty (60) days' prior written notice to HEALTHPLAN. The Agreement may be terminated by HEALTH-PLAN (i) upon ninety (90) days' prior written notice to GROUP of HEALTHPLAN'S decision to discontinue offering this particular type of coverage; or (ii) at the renewal date of the plan, upon one hundred eighty (180) days' prior written notice to GROUP of HEALTHPLAN's decision to discontinue offering all health benefits coverage in Arizona.
2. **Termination for Non-Payment of Fees**. The Agreement may be terminated by HEALTHPLAN for non-payment of any amounts owed to HEALTHPLAN by GROUP under this Agreement, including, but not limited to, Prepayment Fees and Supplemental Charges.
3. **Termination for Fraud or Misrepresentation.** The Agreement may be terminated by HEALTH-PLAN if, at any time, it is determined that GROUP has performed an act or practice that constitutes fraud or intentionally misrepresented a material fact.
4. **Termination for Violation of Participation or Contribution Rules**. The Agreement may be terminated by HEALTHPLAN upon sixty (60) days' prior written notice to GROUP, for the failure of GROUP to comply with a material plan provision relating to GROUP contributions or GROUP participation rules as established by HEALTHPLAN.
5. **Termination Due to Association Membership Ceasing**. HEALTHPLAN may terminate this Agreement, as to a GROUP member of an association with which HEALTHPLAN has entered into this Agreement, when and if the GROUP membership in the association ceases, in accordance with applicable state or Federal law.
6. **Termination Effective Date**. (i) When termination is due to non-payment of amounts described in paragraph 2 above, coverage under the Agreement shall cease immediately upon HEALTHPLAN's notification to GROUP of such termination. (ii) When termination is due to any other reason, coverage shall cease at midnight on the date on which termination occurs.

   GROUP shall be responsible for the payment of all Prepayment Fees due through the date on which coverage ceases. Subscriber shall be financially responsible for services rendered after such date. If GROUP fails to give written notice to Subscriber prior to such date, GROUP shall also be financially responsible for, and shall submit to HEALTHPLAN, all Prepayment fees due after such date until GROUP gives such notice.
7. **Notice of Termination to Members**. In the event the Agreement is terminated under this Section, HEALTHPLAN shall notify Members of the termination effective date. GROUP is responsible for notifying Members of any applicable rights Members may have under the "Continuation of Group Coverage" Section.

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SECTION X: Conversion to Non-Group (Individual) Coverage

In the event a Member loses eligibility for GROUP coverage for any reason described in the "By Reason of Ineligibility" provision of "Section IX: Termination of Member Coverage," and chooses not to, does not properly, or is not eligible to elect Continuation Coverage under "Section XI: Continuation of Group Coverage," the Member may apply for Conversion to Non-Group (Individual) Coverage with HEALTHPLAN on the following terms:

A. **Conversion after Subscriber's Loss of Eligibility**. A Subscriber who continues to reside in the Service Area but has lost eligibility for GROUP coverage and chooses not to, does not properly, or is not eligible to elect Continuation Coverage under the "Continuation of Group Coverage" Section may apply and pay the applicable Prepayment Fee within thirty-one (31) days of the loss of GROUP coverage for Conversion to Non-Group (Individual) Coverage. At the time of Conversion to Non-Group (Individual) Coverage, a Subscriber also may apply for Non-Group Coverage for Dependents who were Members at the time of the loss of eligibility. Upon timely receipt of an application and all Non-Group fees, including all fees for the period since the termination of GROUP coverage, Non-Group Coverage will be effective as of the date of such termination.

B. **Conversion upon Death or Divorce of Subscriber**. Upon the death or divorce of the Subscriber, a Dependent may apply for Conversion to Non-Group (Individual) Coverage under the provisions of Paragraph A of this Section.

C. **Conversion upon Failure to Meet Age Limitation**. A Dependent, who fails to meet the age limitation requirements of the "Eligibility" Section, may apply for Conversion to Non-Group (Individual) Coverage under the provisions of Paragraph A of this Section.

This Section X does not apply where a Member or a Dependent loses eligibility for the reasons described in the "For Cause" or "Termination of Agreement" provisions of the "Termination of Member Coverage" Section.

The benefits, terms and conditions of the Non-Group (Individual Plan) Service Agreement including premiums, Copayments and deductibles, if any, shall be in accordance with the rules of HEALTHPLAN in effect at the time of conversion.

SECTION XI: Continuation of Group Coverage

Continuation of Coverage Under COBRA

This Section shall apply to GROUP and its Members only if GROUP is subject to the requirements of Title X of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and any amendments thereto.

For more detailed information concerning COBRA, Subscriber or Member should contact GROUP.

Qualifying Events for Continuation Coverage

1. **Subscribers.** Subscribers who continue to reside in the Service Area are eligible for Continuation Coverage if they have lost HEALTHPLAN membership eligibility because of termination or reduction of hours of employment, other than for gross misconduct (hereinafter referred to as the "Subscriber Qualifying Event").
2. **Dependents.** Dependents who continue to reside in the Service Area are eligible for Continuation Coverage if they have lost HEALTHPLAN membership eligibility under any of the following events (hereinafter referred to as a "Dependent Qualifying Event"):
   a. death of the Subscriber;
   b. termination or reduction of hours of employment of the Subscriber, other than for gross misconduct;
   c. divorce or legal separation of the Subscriber and the Subscriber's spouse;
   d. a Dependent (child) ceasing to be eligible under the terms of this Agreement.

Election Requirements for Continuation Coverage

A Member who wishes to elect Continuation Coverage shall give notice of this election to GROUP by submitting a signed election form within the Election Period. In turn, GROUP shall submit the election form to HEALTHPLAN within ***fifteen (15) days*** of the end of

the Election Period. Failure to meet both of the above-stated time limitations shall result in denial of Continuation Coverage under this Agreement. The Election Period is defined as the period which:

1. begins not later than the date on which group health coverage terminates under the Plan by reason of a Qualifying Event; and
2. ends not earlier than sixty (60) days after the later of:
   a. the date on which group coverage terminates under this Agreement by reason of a Subscriber or Dependent Qualifying Event; or
   b. in the case of any Subscriber or Dependent who receives written notice of Continuation Coverage, the date of such notice, provided such notice is received within the time limitations specified in "Notice Requirements for Continuation Coverage" of this Section.

   NOTE: The election notice from GROUP to HEALTHPLAN for Continuation Coverage shall be in writing and clearly indicate the Qualifying Event, the date of the Qualifying Event, the date notice was given by the GROUP, and the election date. Except as otherwise specified in writing in an election, any election by a Dependent spouse, or by a Subscriber whose employment has been terminated shall be deemed to include an election of Continuation Coverage on behalf of any other Dependents who would lose coverage under the Plan by reason of the Dependent Qualifying Event. No Member may decline Continuation Coverage on behalf of any other Member, other than a parent or legal guardian who declines coverage on behalf of a minor child.

Continuation Period for Subscribers

A Subscriber who continues to reside in the Service Area and who properly elects Continuation Coverage after a Subscriber Qualifying Event has occurred, shall be covered by HEALTHPLAN until the earliest of the following:

1. eighteen (18) months from the date of termination or reduction of hours of the Subscriber's employment;
2. the date this Agreement terminates;
3. termination of the Subscriber's coverage for non-payment of premium;
4. the date Subscriber becomes entitled to Medicare; or
5. the date on which the Subscriber becomes covered under any other group health plan (as an employee or otherwise), unless the Subscriber has a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

A Member who elects Continuation Coverage is subject to the "Termination of Agreement" provision of the "Termination of Member Coverage" Section.

Continuation Period for Dependents

A Dependent who continues to reside in the Service Area and who properly elects Continuation Coverage after a Dependent Qualifying Event has occurred, shall be covered by HEALTHPLAN until the earliest of the following:

1. eighteen (18) months from the date of termination or reduction of hours of the Subscriber's employment, if that is the Dependent Qualifying Event;
2. thirty-six (36) months from the date of any Dependent Qualifying Event other than Subscriber termination or reduction of hours of employment (except for gross misconduct);
3. the date this Agreement terminates;
4. termination of the Dependent's coverage for non-payment of premiums;
5. the date Dependent becomes entitled to Medicare;
6. the date on which the Dependent becomes covered under any other group health plan (as an employee or otherwise), unless the Dependent has a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

A Dependent who elects Continuation Coverage is subject to the "Termination of Agreement" provision of the "Termination of Member Coverage" Section.

Subsequent Events Affecting Dependent Continuation

The following applies to the Dependent Qualifying Events described in 2. of the "Qualifying Events for Continuation Coverage" Section:

If, within the initial eighteen (18) month continuation period, a Dependent would lose coverage because of an event described in 2.a., 2.c.,

or 2.d., or because of Subscriber's loss of coverage due to Subscriber's subsequent entitlement to Medicare, after Dependent's coverage was continued due to Subscriber's employment termination or reduction in work hours, Dependents may continue coverage for up to thirty-six (36) months from the date of loss of employment or reduction in work hours.

If Subscriber's employment ends or his work hours are reduced within eighteen (18) months after his entitlement to Medicare, Subscriber's covered Dependents may continue coverage for up to thirty-six (36) months from the date Subscriber becomes entitled to Medicare.

If Subscriber's employment ends or his work hours are reduced more than eighteen (18) months after his entitlement to Medicare, covered Dependents may continue coverage for up to eighteen (18) months from the date Subscriber's employment ends or his work hours are reduced.

Disabled Individuals Continuation Provision

If a Member is disabled before or within the first sixty (60) days of continuation coverage which follows termination of employment or a reduction in work hours, the disabled person may continue health insurance for up to an additional eleven (11) months beyond the eighteen (18)-month period.

The disabled person may also continue the coverage for other family members continuously covered for the initial eighteen (18)-month continuation period as either the Subscriber covering a Dependent, or as the Subscriber's Dependent, if they otherwise remain eligible.

To be eligible, a Member must:

1. be declared disabled as of a day before or during the first sixty (60) days of continuation under Title II or XVI by the Social Security Administration; and
2. notify the Plan Administrator of the Social Security Administration's determination within sixty (60) days following the determination and within the initial eighteen (18)-month continuation period, and provide the Plan Administrator with a copy of the determination.

Termination of coverage for all covered persons during the twenty-nine (29)-month period will occur if the disabled person is found by the Social Security Administration to be no longer disabled. Termination for this reason will occur on the first day of the month beginning more than thirty (30) days after the date of the final determination. All reasons for termination which apply to the initial eighteen (18) months will also apply to any or all covered persons for any additional months of coverage.

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Prepayment Fee for Continuation Coverage

A Member who elects Continuation Coverage shall make payment of the Prepayment Fee for said coverage to GROUP within the grace periods specified herein, unless otherwise instructed in writing by HEALTHPLAN. A Member may choose to pay the Prepayment Fee to GROUP in monthly installments, provided that this decision is made in writing at the time Continuation Coverage is elected. A grace period of ***thirty-one (31)*** days will be allowed for each Prepayment Fee payment due from a Member, except for the first Prepayment Fee payment, for which a ***forty-five (45)***-day grace period will be permitted. The first payment shall include all Prepayment Fees due since the date of the Member's Qualifying Event.

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GROUP shall collect and remit each Prepayment Fee payment due from a Member to HEALTHPLAN within ***fifteen (15)*** days of the end of the permitted grace period. Failure to meet all of the above-stated time limitations shall result in termination of the Member's Continuation Coverage under this Agreement. Until the first Prepayment Fee has been received by HEALTHPLAN, a Member's claims will not be paid.

Notice Requirements for Continuation Coverage

1. **Notice by GROUP**. If GROUP has designated a third party as its Plan Administrator, GROUP shall notify the Plan Administrator of the death of Subscriber, termination or reduction of hours or the date Subscriber becomes entitled to Medicare, with respect to any Subscriber who is employed by GROUP, within ***thirty (30)*** days of the date of the Subscriber or Dependent Qualifying Event.
2. **Notice by Subscriber or Dependent**. The Subscriber or Dependent shall notify GROUP or, if applicable, the Plan Administrator of the occurrence of a divorce or legal separation of the Subscriber or a Dependent (child) ceasing to be eligible under the

terms of the Agreement within **sixty (60)** days of the date of the Dependent Qualifying Event.

3. **Notice by GROUP or Plan Administrator**. GROUP or, if applicable, the Plan Administrator shall notify the following persons of their rights under this "Continuation Coverage" Section:
   a. in the case of a death of Subscriber or Subscriber becoming entitled to benefits under Title 18 of the Social Security Act, any Dependent.
   b. in the case of a Subscriber termination or reduction of hours of employment, the Subscriber and any Dependent.
   c. in the case of a divorce or legal separation of the Subscriber or a Dependent (child) ceasing to be eligible where the Subscriber has notified the Plan Administrator as required under "Notice by Subscriber or Dependent," any Dependent.

Such notice shall be given by GROUP or the Plan Administrator within fourteen (14) days of the date on which the Plan Administrator received notice from GROUP, Subscriber, or Dependent, whichever is applicable. Notice to a Dependent spouse shall be treated as notification to all other Dependents residing with such spouse at the time such notification is made. A Member should consult his GROUP for the name and address of the Plan Administrator for that group health plan.

Services and Benefits Under Continuation Coverage

Members who properly elect Continuation Coverage shall be offered the same services and benefits as are offered to Subscribers who are active employees of that GROUP. If the group health plan of a GROUP is changed, these changes shall be applied to the Members who have properly elected Continuation Coverage through that GROUP. There will be no interruption or lapse in coverage for a Member who properly elects Continuation Coverage, provided that all Prepayment Fees due since the date of the Member's Qualifying Event are paid to and received by HEALTHPLAN in a timely manner.

NOTE: If a Member fails to elect or pay Prepayment Fees for Continuation Coverage as required in this Section, that Member and the Subscriber for that Membership Unit shall be responsible for repayment at the Prevailing Rate of all charges by or from HEALTHPLAN for services and benefits provided to that Member under this Agreement.

Conversion to Non-Group (Individual) Coverage Option

A Member, who continues to reside in the Service Area but has lost eligibility for Continuation Coverage as a result of the expiration of the applicable maximum coverage period (e.g., eighteen (18) or thirty-six (36) months from the date of the Qualifying Event) as determined by law, may apply within thirty-one (31) days of the loss of Continuation Coverage for Conversion to Non-Group (Individual) Coverage. The benefits, terms and conditions of the Non-Group (Individual Plan) Service Agreement, including premiums, Copayments and deductibles, if any, shall be in accordance with the rules of HEALTHPLAN in effect at the time of conversion.

Newly Acquired Dependents

If, while your coverage is being continued under this "Continuation of Coverage Under COBRA" Section, you acquire a new Dependent, such Dependent will be eligible for this Continuation provided:

1. the required Prepayment Fee is paid; and
2. HEALTHPLAN is notified of your newly acquired Dependent in accordance with the terms of this Agreement.

However, if event 2.a. or 2.c., of the "Qualifying Events for Continuation Coverage" Section should subsequently occur, a newly acquired Dependent spouse will not be entitled to continue coverage.

If events described in the "Subsequent Events Affecting Dependent Continuation" Section subsequently occur for a child who was born, adopted or placed for adoption as a newly acquired Dependent, coverage will continue according to that Section.

Continuation of Coverage Under the Family and Medical Leave Act of 1993

This Section shall apply to Group and its Members only if Group is subject to the requirements of the federal Family and Medical Leave Act of 1993 and any amendments thereto.

A Subscriber's coverage will continue during a leave of absence if: 1) the leave qualifies as a leave of absence

under the federal Family and Medical Leave Act of 1993; and 2) the Subscriber is an eligible employee or participant in GROUP under the terms of the Act.

During such leave, Subscriber shall pay GROUP the portion of the Prepayment Fee, if any, which Subscriber would have been responsible for, had Subscriber not taken that leave.

GROUP must pay the HEALTHPLAN the Prepayment Fee for Subscriber during such leave, as if Subscriber had not taken a leave of absence.

For more detailed information concerning the federal Family and Medical Leave Act of 1993, Subscriber should contact GROUP.

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SECTION XII: Services and Benefits

Members are entitled to receive the services and benefits set forth in this Section subject to payment of Copayments and Supplemental Charges as specified in the Schedule of Copayments, and subject to the conditions, limitations and exclusions of this Agreement. UNLESS PRIOR WRITTEN APPROVAL OF THE HEALTHPLAN MEDICAL DIRECTOR IS RECEIVED, SERVICES AND BENEFITS SET FORTH BELOW ARE AVAILABLE ONLY IF MEDICALLY NECESSARY, RENDERED BY PARTICIPATING PROVIDERS, AND EITHER PROVIDED OR AUTHORIZED IN WRITING BY THE MEMBER'S PRIMARY CARE PHYSICIAN. HOWEVER, PRIOR WRITTEN AUTHORIZATION BY THE MEMBER'S PRIMARY CARE PHYSICIAN IS NOT REQUIRED FOR "EMERGENCY SERVICES," "OBSTETRICAL AND GYNECOLOGICAL SERVICES," AND "CHIROPRACTIC CARE SERVICES", AS SET FORTH BELOW. SERVICES FROM NON-PARTICIPATING PROVIDERS ARE NOT AVAILABLE EXCEPT AS DESCRIBED IN THE "EMERGENCY SERVICES" PROVISION OF THE "SERVICES AND BENEFITS" SECTION OR WITH THE PRIOR APPROVAL OF THE HEALTHPLAN MEDICAL DIRECTOR.

Physician Services

Physician Services shall include diagnostic and treatment services of Participating Physicians and Other Participating Health Professionals, including office visits; periodic health assessments; hospital care; consultation; and surgical procedures.

Outpatient Services

Outpatient Services shall consist of all services of Participating Providers as requested or directed by the HEALTHPLAN Medical Director or Primary Care Physicians to be provided on an outpatient basis, including diagnostic and/or treatment services; health evaluations, well-child care and routine immunizations in accordance with accepted medical practice; administered drugs, medications, biologicals, and fluids; inhalation therapy; and procedures which can be appropriately provided on an outpatient basis, including certain surgical procedures, anesthesia, the administration of blood and blood products, and recovery room services.

Inpatient Hospital Services

Inpatient Hospital Services are provided upon prior approval of the HEALTHPLAN Medical Director for evaluation or treatment of conditions that cannot be adequately treated on an ambulatory basis or in an Other Participating Health Care Facility. Hospital Services shall include semi-private room and board; care and services in an intensive care unit; drugs, medications, biologicals, fluids and chemotherapy; special diets; dressings and casts; general nursing care; use of operating room and related facilities; the administration of blood and blood products; x-rays, laboratory and other diagnostic services; anesthesia and oxygen services; inhalation therapy; radiation therapy; and such other services customarily provided in acute care hospitals.

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Inpatient Services at Other Participating Health Care Facilities

A Member shall be entitled to Inpatient Services at Other Participating Health Care Facilities for up to sixty (60) days per Contract Year, when medically appropriate as determined by the HEALTHPLAN Medical Director. Services shall include semi-private room and board; skilled and general nursing services, physician visits,

physiotherapy, x-rays, and administration of drugs, medications, biologicals and fluids. In making determinations as to the medical appropriateness, level, or nature of treatment to be provided by a licensed skilled nursing facility, HEALTHPLAN shall, to the extent reasonably possible, follow the Medicare guidelines then in effect on skilled nursing care.

Short-term Rehabilitative Therapy

Short-term Rehabilitative Therapy, including physical, speech and occupational therapy, is provided on an inpatient or outpatient basis. Services provided on an outpatient basis are limited to sixty (60) consecutive days per condition if significant improvement can be expected within sixty (60) days of the first treatment, as determined by the HEALTHPLAN Medical Director. Such coverage is available only for rehabilitation following injuries, surgery or medical conditions. Occupational therapy is provided only for purposes of training Members to perform the activities of daily living.

Home Health Services

Home Health Services are provided for a Member who requires skilled care, is unable to receive medical care on an ambulatory outpatient basis, and does not require confinement in a Hospital or Other Participating Health Care Facility. Home Health Services shall be provided by an accredited home health agency which is a Participating Provider. Home Health Services include visits by professional nurses and Other Participating Health Professionals (including home health aides), consumable medical supplies and durable medical equipment administered or used by such persons in the course of services rendered during such visits, medical social services for the terminally ill, and drugs and medications prescribed by a Participating Physician. Physical, occupational and speech therapy provided in the home are subject to the benefit limitations described under “Short-term Rehabilitative Therapy” in this Section.

Diagnostic Laboratory and Diagnostic and Therapeutic Radiology Services

Diagnostic Laboratory and Diagnostic and Therapeutic Radiology Services shall include electrocardiograms; electroencephalograms; radiation therapy; and other diagnostic and therapeutic procedures.

Maternity Care

Maternity care shall include medical, surgical and hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy. These maternity care benefits also apply to the natural mother of a newborn child legally adopted by Subscriber in accordance with HEALTHPLAN adoption policies and Arizona law.

Voluntary Family Planning Service

Family planning services shall be available to Members on a voluntary basis. These services shall include medical history; physical examination; related laboratory tests; medical supervision in accordance with generally accepted medical practice; other medical services; information and counseling on contraception; implantable/injected contraceptives; and, after appropriate counseling, medical services connected with surgical therapies (vasectomy or tubal ligation).

Services for Infertility

Services for Infertility are covered as authorized by the HEALTHPLAN Medical Director. These include diagnostic services to establish cause or reason for infertility and approved surgical and medical treatment programs that have been established to have a reasonable likelihood of resulting in pregnancy.

Vision and Hearing Screenings

Vision and Hearing Screenings provided by Primary Care Physicians are covered.

Inpatient Mental Health and Substance Abuse Services

Services provided by a facility designated by HEALTHPLAN for the treatment and evaluation of Mental Illness, or rehabilitation when required for a diagnosis and treatment of abuse or addiction to alcohol and/or drugs, are covered upon authorization by the HEALTHPLAN Medical Director or its designee. Such services are limited to thirty (30) days per Contract Year.

The benefits are exchangeable with partial hospitalization sessions of not less than three (3) hours and not more than twelve (12) hours in any twenty-four (24)-hour period. The benefit exchange will be two (2) partial hospitalization sessions equal to one day of inpatient care.

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Outpatient Mental Health Services

Services of Participating Providers qualified to treat Mental Illness are available on an outpatient basis for treatment of conditions such as: anxiety or depression interfering with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; acute exacerbation of chronic mental illness (crisis intervention and relapse prevention). Such services are limited to twenty (20) sessions per Contract Year. Coverage will also be provided for outpatient testing and assessment, as authorized by the HEALTHPLAN Medical Director.

Adjunctive Group Therapy

Coverage will be provided for group therapy programs for treatment of depression, stress, phobia or other emotional disorders, as authorized by HEALTHPLAN.

Outpatient Substance Abuse Rehabilitation Services

Services for outpatient rehabilitation in an individual, group or structured group therapy program are covered, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs and when authorized by the HEALTHPLAN Medical Director. Such services are limited to twenty (20) sessions per Contract Year or one (1) structured program. A Member shall also be entitled to outpatient testing and assessment, when authorized by the HEALTHPLAN Medical Director.

Substance Abuse Detoxification Services

Coverage will be provided for detoxification and related medical ancillary services when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. The HEALTHPLAN Medical Director will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Ambulance Service

A Member is entitled to ambulance service, provided such ambulance service is Medically Necessary and authorized by the HEALTHPLAN Medical Director, or the use of such ambulance service is determined to have been an Emergency Service, as defined in the "Emergency Services" provision of this Section.

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Emergency Services and Urgent Care

Emergency Services are defined as the medical, surgical, hospital and related health care services and testing, including ambulance service, required to treat a sudden unexpected onset of a bodily injury or a serious illness which could reasonably be expected by a prudent layperson to result, in the absence of immediate medical attention, in serious medical complications, loss of life or permanent impairment to bodily functions. Included are conditions which produce loss of consciousness or excessive bleeding; or which may otherwise be determined by the HEALTHPLAN Medical Director in accordance with generally accepted medical standards, to have been a condition requiring immediate medical attention. Emergency Services Care shall also include those services rendered under unforeseen conditions which require hospitalization or services necessary for the repair or accidental injury, relief of acute pain, initial treatment of acute infection, and the amelioration of illness or conditions which, if not immediately diagnosed and treated, would result in extended or permanent physical impairment or loss of life. The presenting symptoms, as coded by the provider and recorded by the Hospital on the UB-92 Claim form or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.

Urgent Care is defined as medical, surgical, hospital and related health care services and testing which are not Emergency Services, but which are determined by the HEALTHPLAN Medical Director in accordance with generally accepted medical standards to have been necessary to treat a condition requiring immediate medical attention. Care which could have been foreseen before leaving the immediate area where Member

ordinarily receives and/or was scheduled to receive services is not covered. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy or care received after a physician's recommendation that the Member should not travel due to any medical condition.

1. **Members are covered for Emergency Services both in and out of the Service Area**. In the event of an emergency, go to the closest emergency room or to the nearest Participating Hospital or call **911** for help. Whenever possible, contact your Primary Care Physician for direction. Participating Providers are on call twenty-four (24) hours a day, seven (7) days a week, to assist Members needing Emergency Services.

   For Emergency Services rendered outside the Service Area, Members must notify HEALTHPLAN as soon as reasonably possible. HEALTHPLAN may, at its option, arrange to have Member transferred to a Participating Provider for continuing or follow-up care whenever medically prudent to do so.
2. **Urgent Care (inside the Service Area**). For Urgent Care inside the Service Area, Members must contact their Primary Care Physician for direction and must receive care from a Participating Provider, unless otherwise authorized by their Primary Care Physician or HEALTHPLAN.
3. **Urgent Care (outside the Service Area).** In the event of a need for Urgent Care while outside the Service Area, Members must contact the HEALTHPLAN for direction and authorization prior to receiving services whenever possible. For services required after hours or on weekends, whenever possible contact your Primary Care Physician for direction and notify the HEALTHPLAN within one (1) business day of receipt of services.
4. **Continuing or Follow-up Treatment.** Continuing or follow-up treatment, whether in or out of the Service Area, is not covered unless rendered by a Participating Provider or authorized in advance by the HEALTHPLAN Medical Director.
5. **Notification, Proof of a Claim, and Payment**. Inpatient hospitalization for any Emergency Services requires notification to and authorization by the HEALTHPLAN Medical Director within ***forty-eight (48)*** hours of admission. This requirement shall not cause denial of an otherwise valid claim if the Member could not reasonably comply, provided that notification is given to HEALTHPLAN as soon as reasonably possible or for an initial medical screening examination and any immediately necessary stabilizing treatment without prior authorization by the plan. Any Member receiving Emergency Services from non-Participating Providers must submit a claim to HEALTHPLAN no later than sixty (60) days after the first Emergency Service is provided. The claim shall contain an itemized statement of treatment, expenses, and diagnosis. This requirement shall not cause denial of an otherwise valid claim if the Member could not reasonably comply, provided the claim and the itemized statement are submitted to HEALTHPLAN as soon as reasonably possible. Coverage for Emergency Services received through Non-Participating Providers shall be limited to services to which the Member would have been entitled under this Agreement, which shall be reimbursed at generally Prevailing Rates in the area where the Emergency Services were provided.

Internal Prosthetic/Medical Appliances

Coverage for Internal Prosthetic/Medical Appliances authorized by the Primary Care Physician consists of permanent or temporary internal aids and supports for defective body parts. Repair or maintenance of a covered appliance is covered.

Breast Reconstruction and Breast Prostheses

Following a mastectomy, the following are considered covered services and benefits:

- surgical services for reconstruction of the breast on which surgery was performed;
- surgical services for reconstruction of the nondiseased breast to produce symmetrical appearance;
- post-operative breast prostheses; and
- two mastectomy bras per Contract Year.

During all stages of mastectomy, treatment of physical complications, including lymphedema, are covered.

Organ Transplant Services

A Member is entitled to receive benefits for human organ and tissue transplant services at limited facilities throughout the United States, as designated by

HEALTHPLAN, subject to the conditions and limitations below.

A. **DEFINITION OF TRANSPLANT SERVICES.** Transplant services are the recipient's medical, surgical and hospital services, inpatient immunosuppressive medications, and organ procurement required to perform any of the following human-to-human organ or tissue transplants: kidney, cornea, bone marrow, heart, heart/lung, lung, liver or pancreas.

B. **PREAUTHORIZATION**. Coverage of transplant services must be authorized by the HEALTHPLAN Medical Director based on the medical criteria and methodology employed by a transplant facility designated by HEALTHPLAN.

C. **ORGAN PROCUREMENT COSTS**. Coverage of organ procurement costs is limited to costs directly related to the procurement of an organ from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Coverage for compatibility testing undertaken prior to procurement shall be limited to the testing of cadavers and donors having a blood relationship to the recipient.

The benefits set forth in this Section are available only where a facility designated by HEALTHPLAN is utilized and the Member is the recipient of an organ transplant. No benefits are available where the Member is a donor.

Nutritional Evaluation

Initial nutritional evaluation and counseling from a Participating Provider is provided when diet is part of the medical management of a documented disease, including morbid obesity.

Diabetes Treatment

Coverage will be provided for the following Medically Necessary supplies, devices, and appliances prescribed by a health care provider for the treatment of diabetes:

- Text strips for glucose monitors and visual reading and urine testing strips;
- Insulin preparations;
- Glucagon;
- Insulin cartridges and insulin cartridges for the legally blind;
- Syringes and lancets (including automatic lancing devices);
- Oral agents for controlling blood sugar that are included on the Formulary;
- Blood glucose monitors and blood glucose monitors for the legally blind;
- Injection aids.

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Hospice Services

Hospice Care Services when provided, due to Terminal Illness, under a Hospice Care Program are covered. Hospice Care Services shall include inpatient care; outpatient services; professional services of a Physician; services of a psychologist, social worker or family counselor for individual and family counseling; and Home Health Services.

Hospice Care Services do not include the following:

- services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- services or supplies not listed in the Hospice Care Program;
- services for curative or life-prolonging procedures;
- services for which any other benefits are payable under the Agreement;
- services or supplies that are primarily to aid you or your Dependent in daily living;
- bereavement counseling;
- services for respite care;
- nutritional supplements, non-prescription drugs or substances, medical supplies, vitamins, or minerals.

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Obstetrical and Gynecological Services

Members are allowed direct access to a qualified Participating Provider for obstetrical and gynecological services covered by this plan. Members are not required to obtain authorization from their Primary Care Physician for visits to the Participating Provider of their choice for pregnancy, well-women gynecological exams,

primary and preventive gynecological care and acute gynecological conditions.

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Chiropractic Care Services

Non-surgical and noninvasive treatment rendered by an Arizona-licensed chiropractor who is a Participating Provider of neck and back pain through physiotherapy, musculoskeletal manipulation and other physical corrections of musculoskeletal conditions within the scope of chiropractic practice as defined by state law. Musculoskeletal means any function of the musculoskeletal system that is integrated with neurological function and is expressed by biological regulatory mechanisms. This benefit is limited to twelve (12) direct access visits per contract year; you do not need a referral from your PCP.

Medical Foods (This benefit is covered only if your Group has purchased Prescription Drug Coverage)

Medical foods to treat inherited metabolic disorders. Metabolic disorders triggering medical food coverage are: (a) part of the newborn screening program as prescribed by Arizona statute; (b) involve amino acid, carbohydrate or fat metabolism; (c) have medically standard methods of diagnosis, treatment and monitoring including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues; and (d) require specifically processed or treated medical foods that are generally available only under the supervision and direction of a physician, that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.

We will cover up to 50% of the cost of medical foods prescribed to treat inherited metabolic disorders covered under this contract. There is a miximum annual limit for medical foods of $5,000 which applies to the cost of all prescribed modified low protein foods and metabolic formula.

For the purpose of this section, the following definitions apply:

l. "Inherited Metabloic Disorder" means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under the newborn screening program as prescribed by Arizona statute.

2. "Medical Foods" means modified low protein foods and metabolic formula.

3. "Metabolic Formula" mean foods that are all of the following: (a) formulated to be consumed or administered enternally under the supervision of a medical doctor or doctor of osteopathy; (b) processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs; (c) administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; and (d) essential to a person's optimal growth, health and metabolic homeostasis.

4. "Modifed Low Protein Foods" means foods that are all of the following: (a) formulated to be consumed or administered enternally under the supervision of a medical doctor or doctor of osteopathy; (b) processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein; (c) administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrients requirements as established by medical evaluation; (d) essential to a person's optimal growth, health and metabolic homeostatis.

Cancer Clinical Trials

Coverage shall be provided for medically necessary covered patient costs that are directly associated with a cancer clinical trial that is offered in the State of Arizona and in which the Member participates voluntarily. A cancer clinical trial is a course of treatment in which all of the following apply:

1. The treatment is part of a scientific study of a new therapy or intervention that is being conducted at an institution in the State of Arizona, that is for the treatment, palliation or prevention of cancer in humans and in which the scientific study includes all of the following: (a) specific goals; (b) a rationale and background for the study; (c) criteria for patient selection; (d) specific directions for administering the therapy and monitoring patients; (e) definition of quantitative measures for determining treatment response; and (f) methods for documenting and treating adverse reactions.

2. The treatment is being provided as part of a study being conducted in a phase I, phase II, phase III or phase IV cancer clinical trial.
3. The treatment is being provided as part of a study being conducted in accordance with a clinical trial approved by at least one of the following: (a) One of the National Institutes of Health; (b) A National Institutes of Health Cooperative Group or Center; (c) The United States Food and Drug Administration in the form of an investigational new drug application; (d) The United States Department of Defense; (e) The United States Department of Veteran Affairs; (f) a qualified research entity that meets the criteria established by the National Institutes of Health for grant eligibility; or (g) a panel of qualified recognized experts in clinical research within academic health institutions in the State of Arizona.
4. The proposed treatment or study has been reviewed and approved by an institutional review board of an institution in the State of Arizona.
5. The personnel providing the treatment or conducting the study (a) are providing the treatment or conducting the study within their scope of practice, experience and training and are capable of providing the treatment because of their experience, training and volume of patients treated to maintain expertise; (b) agree to accept reimbursement as payment in full from the Healthplan at the rates that are established by the Healthplan and that are not more than the level of reimbursement applicable to other similar srevices provided by the health care providers within the Healthplan's network.
6. There is no clearly superior, noninvestigational treatment alternative.
7. The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as any noninvestigational alternative.

For the purposes of this specific covered Service and Benefit the following have the following meaning:

1. "**Cooperative Group**" -means a formal network of facilities that collaborates on research projects and that has an established national institutes of health approved peer review program operating within the group, including the National Cancer Institute Clinical Cooperative Group and The National Cancer Institute Community Clinical Oncology Program.
2. "**Institutional Review Board**" -means any board, committee or other group that is both: (a) formally designated by an institution to approve the initiation of and to conduct periodic review of biomedical research involving human subjects and in which the primary purpose of such review is to assure the protection of the rights and welfare of the human subjects and not to review a clinical trial for scientific merit; and (b) approved by the National Institutes of Health Office for Protection From Research Risks.
3. "**Multiple Project Assurance Contract**" -means a contract between an institution and the United States Department of Health and Human Services that defines the relationship of the institution to the United States Department of Health and Human Srvices and that sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.
4. "**Patient Cost**" -means any fee or expense that is covered under the Evidence of Coverage and that is for a service or treatment that would be required if the patient were receiving usual and customary care. Patient Cost does not include the cost: (a) of any drug or device provided in a phase I cancer clinical trial; (b) of any investigational drug or device; (c) of nonhealth services that might be required for a person to receive treatment or intervention; (d) of managing the research of the clinical trial; (e) that would not be covered under the Member's contract; and (f) of treatment or services provided outside the State of Arizona.

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SECTION XIII: Exclusions and Limitations

Exclusions

Any services and benefits which are not described in the “Services and Benefits,” Section or in an attached Rider are excluded from coverage under this Agreement.

By way of example, but not of limitation, except as otherwise described in Section XII: Services and Benefits, the following are specifically excluded services and benefits:

1. Any services, except “Emergency Services”, “Obstetrical and Gynecological Services” and "Chiropractic Care Services" which are provided

without the prior written approval of the HEALTHPLAN Medical Director or Member's Primary Care Physician and any services, except "Emergency Services" which are not rendered by Participating Providers.

2. Any services which do not meet the definition of Medically Necessary/Medical Necessity.
3. Care for health conditions which are required by state or local law to be treated in a public facility.
4. Care for military services disabilities treatable through governmental services if the Member is legally entitled to such treatment and facilities are reasonably available.
5. Assistance in the activities of daily living, including, but not limited to, eating, bathing, dressing or other custodial or self-care activities, homemaker services, and services primarily for rest, domiciliary, or convalescent care.
6. Any services and benefits which are Experimental, Investigational or Unproven Services.

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7. Organ transplants except as set forth in the "Organ Transplant Services" provision of the "Services and Benefits" Section.
8. Cosmetic therapy or surgical procedures primarily for the purpose of altering appearance. The exclusions include surgical excision or reformation of any sagging skin on any part of the body, including, but not limited to, the eyelids, face, neck, abdomen, arms, legs or buttocks; and services performed in connection with the enlargement, reduction, implantation, or change in appearance of a portion of the body, including, but not limited to, the breast, face, lips, jaw, chin, nose, ears or genitals; hair transplantation; chemical face peels or abrasion of the skin; electrolysis depilation; or any other surgical or non-surgical procedures which are primarily for the purpose of altering appearance. This provision will not exclude services or benefits that are primarily for the purpose of restoring a normal bodily function, or surgery which is Medically Necessary.
9. All medical and surgical services for the treatment or control of obesity, unless Medically Necessary.
10. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic, or custodial evaluations.
11. Court ordered treatment or hospitalization, unless such order is being sought by a Participating Physician or unless otherwise covered under the "Services and Benefits" Section.
12. Treatment for mandibular or maxillary prognathism, microprognathism or malocclusion, surgical augmentation for orthodontics, or maxillary constriction. Medically necessary treatment of TMJ shall not be excluded.

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2001-A

13. Dental treatment of the teeth or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition.
14. Reversal of voluntary sterilization procedures.
15. Infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization and embryo transplantation, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, preparation or storage of sperm for artificial insemination (including donor fees).
16. Transsexual surgery (including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery).
17. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
18. Non-medical ancillary services such as vocational rehabilitation, behavioral training, sleep therapy, employment counseling, psychological counseling and training or educational therapy for learning disabilities or mental retardation.
19. Therapy to improve general physical condition including, but not limited to, cardiac rehabilitation and pulmonary rehabilitation programs, and any rehabilitative therapy except as provided in the "Short-term Rehabilitative Therapy" provision of the "Services and Benefits" Section.
20. Consumable medical supplies and durable medical equipment including, but not limited, to bandages and other disposable medical supplies, skin

preparations, test strips, and ostomy supplies; wheelchairs, hospital beds and any custom-fitted medical equipment, except where used as part of services provided under the "Inpatient Hospital Services" and "Outpatient Services" provisions or as specified in the "Home Health Services" and "Diabetes Treatment" provisions of the "Services and Benefits" Section.

21. Private hospital rooms and/or private duty nursing unless determined to be Medically Necessary by the HEALTHPLAN Medical Director.

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22. Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complementary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
23. Artificial aids, including, but not limited to, crutches; splints; braces; corrective orthopedic shoes; arch supports; elastic stockings; garter belts; corsets; hearing aids; eyeglass lenses and frames; contact lenses (except for the treatment of keratoconus or post-cataract surgery); dentures and wigs.
24. External and internal prosthetic medical appliances, including, but not limited to, artificial arms; legs; and terminal devices such as a hand or hook; penile prosthetic appliances; biomechanical devices and experimental or investigational devices.
25. Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
26. Treatment by acupuncture.
27. Adjustment or manipulation of the spine except as provided under the "Short-term Rehabilitation Therapy" or "Chiropractic Care Services" provision of the "Services and Benefits" Section.
28. All prescription drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in the "Inpatient Hospital Services" or "Diabetes Treatment" provisions of the "Services and Benefits" Section.
29. Routine foot care, including the paring and removing of corns and calluses or trimming of nails, unless Medically Necessary for treatment of a person, due to a demonstrated medical condition.
30. Membership costs or fees associated with health clubs and weight loss clinics.
31. Amniocentesis, ultrasound, or any other procedures requested solely for sex determination of a fetus, unless Medically Necessary to determine the existence of a sex-linked genetic disorder.

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32. Fees associated with the collection or donation of body organs.
33. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
34. Cosmetics, dietary supplements, nutritional formulae, and health and beauty aids.
35. Services and benefits related to treatment of Mental Illness and substance abuse conditions which are not described in the "Services and Benefits" Section are excluded from coverage. These excluded services include, but are not limited to, the following:
    - Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation, or custody or visitation evaluations unless Medically Necessary and covered under the "Services and Benefits" Section of this Agreement.
    - Treatment of organic mental disorders associated with permanent dysfunction of the brain.
    - Developmental disorders, including, but not limited to, developmental reading disorders, developmental arithmetic disorder, developmental language disorder or developmental articulation disorder.
    - Counseling for activities of an educational nature.
    - Counseling for borderline intellectual functioning.
    - Counseling for occupational problems.
    - Counseling related to consciousness raising.
    - Vocational or religious counseling.
    - I.Q. testing.
    - Psychological testing on children requested by or for a school system, unless Medically Necessary and covered under the "Services and Benefits" Section of this Agreement.

36. Penile implants, unless Medically Necessary.

In addition to the provisions of this "Exclusions and Limitations" Section, Member will be responsible for payments on a fee-for-service basis for services and benefits under the conditions described in the "Reimbursement" provision of the "Relation of the Agreement to Other Sources of Payment for Health Services" Section.

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Limitations

Circumstances Beyond HEALTHPLAN's Control. To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within the control of HEALTHPLAN results in the facilities, personnel, or financial resources of HEALTHPLAN being unavailable to provide or arrange for the provisions of a basic or supplemental health service or benefit in accordance with this Agreement, HEALTHPLAN shall make a good faith effort to provide or arrange for the provision of the service or benefit, taking into account the impact of the event.

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SECTION XIV: Complaints and Grievance Procedure

Benefit Inquiry and Appeals Process

The following describes the process by which Members may obtain information and submit concerns regarding service, benefits, and coverage. For more information, see the Benefit Inquiry and Appeals Process Information Packet. Upon membership renewal, you may request an additional Benefit Inquiry and Appeals Process Information Packet by contacting Member Services at 1.800.832.3211.

I. Overview of Benefits Confirmation and Appeal Process

All Members may inquire about their benefits at any time by contacting CIGNA HealthCare Member Services as described below. You may request that HEALTHPLAN review its decisions involving a request for service or denial of a claim. In general, the following levels involving benefit information and appeal processes, all discussed below, are available to all Members:

- Benefit Inquiry
- Expedited Review or Complaint Review
- Grievance Review
- External Independent Review

II. Benefit Inquiry

As a Member of HEALTHPLAN, your first point of contact for questions about benefit coverage or payment of claims is a Member Services Representative at CIGNA HealthCare Member Services at the telephone number listed on the back of your CIGNA identification card. Member Services is open to take your call Monday - Friday 7 a.m. - 9 p.m. and Saturday 8 a.m. - 5 p.m.

If your concern is not resolved to your satisfaction during your discussion with your Member Services Representative, you may request that HEALTHPLAN reconsider its prior decision. It is recommended, but not required, that you submit your request for review in writing to the Member Services Representative who handled your call. The Member Services Representative will refer your complaint to the HEALTHPLAN Appeal Coordinator at the Complaint level. If an Expedited Review is necessary, the Member Services Representative will refer your case to the HEALTHPLAN Appeal Coordinator at the Expedited Review level. See Sections III. A. and B. below.

If you wish to submit your review request verbally during your call, without putting it in writing, your Member Services Representative will take your review request and immediately refer your case to the HEALTHPLAN Appeal Coordinator at the Complaint or Expedited Review level, as appropriate.

III. Appeal Process

A. Expedited Review (pursuant to A.R.S. § 20-2534 - expedited medical review)

1. Eligibility

a. Request for a service not yet provided:

For a service that has not already been provided, you may obtain an Expedited Review, if:

- Your request for a service has been

denied; and

- Your primary care physician ("PCP") or treating provider certifies in writing and provides supporting documentation that the time required to process your request through the Complaint and Grievance process if likely to cause a significant negative change in your medical condition. The certification and supporting documentation should be sent to Member Services. Your Member Services Representative will immediately refer your Expedited Review request to the Healthplan Appeal Coordinator.

b. Request for payment of a denied claim:

You may not obtain Expedited Review of a denied claim. Instead, you may initiate the Complaint Review process (see Section III.B. below) by calling a Member Services Representative at Member Services.

2. Decision Process

Within one (1) business day of receipt of your review request and the accompanying certification and the supporting documentation, HEALTHPLAN will make an Expedited Review decision and telephonically provide and mail a notice of that decision to you and your PCP or treating provider.

a. Denial upheld

If HEALTHPLAN agrees with its denial of the requested service, notice of the decision will include the criteria used and the clinical reasons for that decision and any references to supporting documentation.

If HEALTHPLAN upholds the denial of the requested service, you may request further review at the Grievance Expedited Appeal level.

b. Denial reversed

If HEALTHPLAN reverses its prior denial of a service, you will be notified and the requested service will be authorized.

Expedited Appeal Level

1. Eligibility

a. Request for a service not yet provided:

For a service that has not already been provided, you may obtain an Expedited Appeal Level Review, if:

Your request for a service has ben denied under the Expedited Review; and

Your primary care physician (PCP) or treating provider immediately submits a written appeal of the denial of the service and provides the Healthplan with any additional material justification or documentation to support your request for the service. The certification and supporting documentation should be sent to Member Services. Your Member Services Representative wil immediately refer your Expedited Review request to the Healthplan Appeal Coordinator

b. Request for payment of a denied claim:

You may not obtain Expedited Appeal Level Review of a denied claim. Instead, you may initiate the Complaint Review Process (see Section III.B below) by calling a Member Services Representative at Member Services.

2. Decision Process

Within 3 business days of receipt of your review request, and the accompanying certification and the supporting documentation, the Healthplan will make an Expedited Appeal Level Review decision and telephonically provide and mail a notice of that decision to you and your PCP or treating provider.

a. Denial upheld

If the Healthplan agrees with its denial of the requested service, notice of the denial will include the criteria used and the clinical reasons for that decision and any references to supporting documentation.

If the Healthplan upholds the denial of the requested service, you may request an External Independent Review. See Section III.D. below.

b. Denial reversed

If the Healthplan reverses its prior denial of a service, you will be notified and the requested service will be authorized.

B. Complaint Review (pursuant to A.R.S. § 20-2535 - Informal Reconsideration)

1. Eligibility

If you were unable to resolve your concern during your discussion with the Member Services Representative at Member Services, you may request review of HEALTHPLAN's decision at the Complaint level for up to two (2) years after the initial denial of the requested service or payment for the service. A written request for review is recommended, but not required. Upon receipt of your Complaint, the Member Services Representative will forward your appeal to the HEALTHPLAN Complaint Appeal Coordinator. If you wish to submit your review request orally, without putting it in writing, the Member Services Representative will take your complaint and immediately refer your case to the HEALTHPLAN Appeal Coordinator. You may forward your request for review to Member Services.

2. Deadlines Applicable to the Complaint Process

Within five (5) business days after receiving your request for review at the Complaint level, HEALTHPLAN will mail you and your PCP or treating provider:

- a notice indicating that your request was received, and
- a copy of the Information Packet.

3. Decision Process

HEALTHPLAN will make a decision and mail a notice of that decision to you and your PCP or treating provider within thirty (30) calendar days of receiving your review request.

a. Denial upheld

If HEALTHPLAN upholds its denial of the requested service or the denied claim, the notice of that decision will include the criteria used and the clinical reasons for that decision and any references to supporting documentation. You may request further review at the Grievance level. (See Section III.C. below.)

b. Denial reversed

If HEALTHPLAN agrees that the requested service should be provided or that the claim should have been paid, HEALTHPLAN will authorize the service or pay the claim.

C. Grievance Review (pursuant to A.R.S. § 20-2536 - formal appeal)

1. Eligibility

If HEALTHPLAN denies:

- your request for a service not already provided after review at either Expedited Review or the Complaint level, or
- a claim for a service that has already been provided after review at the Complaint level,
- you may send a written request for review at the Grievance level.

Please send your review request relating to denial of a requested service that has not already been provided within sixty (60) calendar days of the last denial. Your review requests relating to payment of services already provided should be sent within two (2) years of the last denial.

Along with your written request for review at the Grievance level, you or your PCP or treating provider are required to submit to HEALTHPLAN in writing:

- any material justification or documentation to support your request for a service not already provided or payment for a service already provided.

At the Grievance level, all Members will be given the option of participating in person, via conference call, or other technology at the Grievance Committee meeting. This is not a formal legal proceeding.You may attend with a representative or a representative may attend on your behalf. If a representative attends on your behalf, an executed Release of Medical Information is required prior to the meeting.

2. Deadlines Applicable to the Grievance Process

Within five (5) business days after receiving your request for review at the Grievance level, HEALTHPLAN will send you and your PCP or treating provider:

- a notice indicating that your request was received and an opportunity to appear at the Grievance Committee meeting, and
- another copy of the Information Packet. Effective 3/1/01 a copy of the Information Packet willnot beincluded with the acknowledgment letter.

3. Decision Process

Within the thirty (30) calendar days from the date HEALTHPLAN receives your Grievance Review request, HEALTHPLAN will make a decision and mail notice of that decision to you and your PCP or treating provider.

a. Denial upheld

If HEALTHPLAN upholds its denial of the requested service or claim for a service that has already been provided, you will receive:

- written notice which includes the criteria used and the clinical reasons for that decision and any references to supporting documentation, and
- written notice of the option to proceed to External Independent Review.

b. Denial reversed

If HEALTHPLAN agrees that the requested service should be provided or that the claim should have been paid, HEALTHPLAN will authorize the service or pay the claim.

c. External Independent Review Option

If you choose not to attend the Grievance Committee meeting, HEALTHPLAN may send your case directly to External Independent Review without making a decision at the Grievance Review level.

D. Non-Expedited External Independent Review

1. Eligibility

Under Arizona law, a Member may seek External Independent Review only after seeking any available Expedited Review, Complaint Review, and Grievance Review. Your request for External Independent Review should be submitted in writing.

2. Deadlines Applicable to the External, Independent Review Process

After receiving written notice from HEALTHPLAN that your appeal at the Grievance level has been denied, you have thirty (30) calendar days to submit a written request to HEALTHPLAN for External Independent Review. Your request must include any material justification or documentation to support your request for the service or payment of a claim.

a. Medical Necessity Issues

If your appeal for External Independent Review involves an issue of medical necessity:

(1) Within five (5) business days of receipt of your request for External Independent Review, HEALTHPLAN will:

- mail a written notice to you, your PCP or treating provider, and the Director of the Arizona Department of Insurance ("Director of Insurance") of your request for External Independent Review, and
- Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

(2) Within 5 days of receiving our informaiton, the Insurance Director must send all the submitted

information to an external independent review organization (the "IRO").

(3) Within 21 days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.

(4) Within 5 business days of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to us, you, and your treating provider.

b. Coverage Issues

If your appeal for External Independent Review involves an issue of service or benefits coverage or a denied claim:

(1) Within five (5) business days of receipt of your request for External Independent Review, HEALTHPLAN will:

- mail a written notice to you, your PCP or treating provider, and the Director of Insurance of your request for External Independent Review, and
- send the Director of Insurance: your request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision the criteria used and any clinical reasons for our decision; and the relevant portions of our utilization review guidelines.

(2) Within fifteen (15) business days of the Director's receipt of your request for External Independent Review from HEALTHPLAN, the Director of Insurance will:

- determine whether the service or claim is covered, and
- mail the decision to the HEALTHPLAN. If the Director decides that we should provide the service or pay the claim, we must do so.

(3) If the Director of Insurance is unable to determine an issue of coverage, the Director will forward your case to an IRO. The IRO will have 21 days to make a decision and send it to the Insurance Director. The Insurance Director will have 5 business days after receiving the IRO's decision to send the decision to us, you, and your treating provider.

3. Decision Process

HEALTHPLAN will provide any covered service or pay any covered claim determined to be medically necessary by the independent reviewer(s) and provide any service or pay any claim determined to be covered by the Director of Insurance regardless of whether HEALTHPLAN elects to seek judicial review of the decision made through the External Independent Review Process.

4. Judicial Review

If you disagree with the final decision of the independent reviewer(s) or the Director of Insurance, you may seek judicial review. If HEALTHPLAN disagrees with the final decision of the independent reviewer(s) or the Director of Insurance, it may seek judicial review, provided that HEALTHPLAN will provide any covered service or pay any claim determined to be medically necessary by the independent reviewer(s) regardless of whether it elects to seek judicial review.

E. Expedited External Independent Review

1. Eligibility

Under Arizona law, a Member may seek an Expedited External Independent Review, after receiving an adverse decision for a covered service or claim at the Expedited Medical Review Level.

2. Deadlines Applicable to the Expedited External Independent Review Process

After receiving written notice from the Healthplan that our appeal at the Expedited Medical Review Level has been denied, you have 5 business days to submit a written request to the Healthplan for an Expedited

External Independent Review. Your request must include any material justification or documentation to support our request for the service or payment of a claim.

a. Medical Necessity Issues

If your appeal for Expedited External Independent Review involves an issue of medical necessity:

(1) Within 1 business day of receipt of your request for an Expedited External Independent Review, the Healthplan will:

- mail a written acknowledgment to you, your PCP or treating provider,and the Director of your request for Expedited External Independent Review, and
- forward to the Director your request for an Expedited External Independent Review, the terms of the agreement in your contract, all medical records and supporting documentation used to render the adverse decision, a summary description of the applicable issues including a statement of the Healthplan's decision, the criteria used and the clinical reasons for the decision, relevant portions of the Healthplan's utilization review plan and the name and the credentials of the licensed health care provider who reviewed the case.

(2) Within 2 business days after the Director receives the information outlined above, the Director will choose an independent review organization (IRO) and forward to the organization all of the information received by the Director.

(3) Within 5 business days of receiving a case for Expedited External Independent Reivew from the Director, the IRO will evaluate and analyze the case and based on all the information received, render a decision and send the decision to the Director. Within 1 business day after receiving a notice of the decision from the IRO, the Director will mail a notice of the decision to you, your PCP or treating provider, and the Healthplan.

b. Coverage Issues

If your appeal for Expedited External Independent Review involves an issue of service or benefits coverage or a denied claim:

(1) Within 1 business day of receipt of your request for an Expedited External Review, the Healthplan will:

- mail a written acknowledgment to you, your PCP or treating provider, and the Director of your request for Expedited External Independent Review, and
- forward to the Director your request for a Expedited External Independent Review the terms of the agreement in your contract, all medical records and supporting documentation used to render the adverse decision, a summary description of the applicable issues including a statement of the Healthplan's decicion, the criteria used and the clinical reasons for the decision, relevant portions of the Healthplan's utilization review plan and the name and the credentials of the licensed health care provider who reviewed the case.

(2) Within 2 business days after receipt of all the information outlined above, the Director will determine if the service or claim is covered and mail a notice of the determination to you, your PCP or treating provider, and the Heathplan.

3. Decision Process

The Healthplan will provide any covered service or pay any covered claim determined to be medically necessary by the independent reviewer(s) and provide any service or pay any claim determined to be covered by the Director regardless of whether the Healthplan elects to seek judicial review of the decision made through the External Independent Review Process.

4. Judicial Review

If you disagree with the final decision of the independent reviewer(s) or the Director, you may seek judicial review. If the Healthplan disagrees with the final decision of the independent reviewer(s) or the Director, it may seek judicial review, provided that the Healthplan will provide any covered service or pay any claim determined to be medically necessary by the independent reviewer(s) regardless of whether it elects to seek judicial review.

Under Arizona law, if you intend to file suit regarding a denial of benefit claim r services you believe are medically necessary, you are required to provide written notice to the Healthplan at least thirty (30) days before filing the suit stating our intention to file suit and the basis for your suit. You must include in your notice the following:

Member Name
Member Identification Number
Member Date of Birth
Basis of Suit (reasons, facts, date(s) of treatment or request)

Notice will be considered provided by you on the date received by the Healthplan. The notice of intent to ifle suit must be sent to the Healthplan via Certified Mail Return Receipt Request to the following address:

Attention: Appeals Supervisor
Notice of Intent to File Suit
CIGNA HealthCare of Arizona
11001 N. Black Canyon Highway
Phoenix, AZ 85029

IV. Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document required to be mailed during the process discussed in this information packet is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. "Properly addressed" means your last known address.

V. Complaints to the Arizona Department of Insurance

The Director of the Arizona Department of Insurance is required by law to require any Member who files a complaint with the Arizona Department of Insurance relating to an adverse decision to first pursue the review process established by the Arizona Legislature and HEALTHPLAN as described above.

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SECTION XV: Relation of the Agreement to Other Sources of Payment for Health Services

Reimbursement

In the event a Member receives payment from a third person, organization, or governmental entity including, but not limited to, Workers' Compensation, Medicare, or the Member's insurance carrier for health services which have been rendered by HEALTHPLAN or which have been paid by HEALTHPLAN, HEALTH-PLAN shall have a right to receive reimbursement from the Member to the extent that the Member has received payment, as follows:

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1. Where HEALTHPLAN has directly rendered or arranged for the rendering of services, HEALTHPLAN shall have a right to reimbursement from the Member to the extent of the Prevailing Rates for the care and treatment so rendered.
2. Where HEALTHPLAN does not render services but pays for those services which are within the scope of the "Services and Benefits" Section of the Agreement, HEALTHPLAN shall have a right of reimbursement from the Member to the extent that HEALTHPLAN has made payments for the care and treatment so rendered.

In addition, it is the Member's obligation to fully cooperate with any attempts by HEALTHPLAN to recover such expenses against the Member's employer in the event that coverage is not available as a result of the

failure of the employer to take the steps required by law or regulation in connection with such coverage.

Coordination of Services and Benefits

Applicability. This Coordination of Benefits (COB) provision applies when a Member has health care coverage under more than one Plan. ("Plan" is defined below.)

If a Member is covered by this Agreement and another Plan, the Order of Benefit Determination Rules described below determine whether this Agreement or the other Plan is Primary. The benefits of this Agreement:

1. shall not be reduced when, under the Order of Benefit Determination Rules, this Agreement is Primary; but
2. may be reduced for the Reasonable Cash Value of any service provided under this Agreement that may be recovered from another Plan when, under the Order of Benefit Determination Rules, the other Plan is Primary. (The above reduction is described in the subsection below entitled "Effect on the Benefits of this Agreement.")

Definitions. "Plan" means any of the following coverages that provides benefits or services for, or because of, medical care or treatment:

1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage.
2. Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX of the United States Social Security Act, as amended from time to time). It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.
3. Medical benefits coverage of group, group-type and individual "no-fault" and traditional automobile "fault" contracts.

Each contract or other arrangement for coverage under 1, 2, or 3 above is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

"Primary" means that a Plan's benefits are to be provided or paid without considering any other Plan's benefits. (The Order of Benefit Determination Rules below determine whether a Plan is Primary or Secondary to another Plan.)

"Secondary" means that a Plan's benefits may be reduced and it may recover the Reasonable Cash Value of the services it provided from the Primary Plan. (The Order of Benefit Determination Rules below determine whether a Plan is Primary or Secondary to another Plan.)

"Allowable Expense" means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made. Allowable expense does not include coverage for dental, vision or hearing care.

1. When this Agreement provides services, the Reasonable Cash Value of each service is the Allowable Expense and is a benefit paid.
2. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is Medically Necessary either in terms of generally accepted medical practice or as specifically defined in the Plan.

"Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a Member has no coverage under this Agreement, or any part of a year before the date this COB provision or a similar provision takes effect.

"Reasonable Cash Value" means an amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules. When a Member receives services through this Agreement or is otherwise entitled to claim benefits under this Agreement, and the services or benefits are a basis for a claim under another Plan, this Agreement shall be Secondary and the other Plan shall be Primary, unless:

1. the other Plan has rules coordinating its benefits with those of this Agreement; and

2. both the other Plan's rules and this Agreement's rules, as stated below, require that this Agreement's benefits be determined before those of the other plan.

This Agreement determines its Order of Benefits using the first of the following rules that applies:

1. The Plan under which the Member is an employee shall be Primary.
2. If the Member is not an employee under a Plan, then the Plan which covers the Member's parent (as an employee) whose birthday occurs earlier in a calendar year shall be Primary.

   NOTE: The word "birthday" as used in this subparagraph refers only to month and day in a calendar year, not to the year in which the person was born. To aid in the interpretation of this paragraph, the following example is given: If a Member's mother has a birthday on January 1 and the Member's father has a birthday on January 2, the Plan which covers the Member's mother would be Primary.

3. If two or more Plans cover a Member as a Dependent child of divorced or separated parents, benefits for the Member shall be determined in the following order:
   a. first, the Plan of the parent with custody of the child;
   b. then, the Plan of the spouse of the parent with custody of the child; and
   c. finally, the Plan of the parent not having custody of the child.
4. Notwithstanding subparagraph 3 above, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan shall be Primary. This subparagraph 4 does not apply with respect to any Claim Determination Period or plan year in which benefits are paid or provided before the entity has that actual knowledge.
5. The benefits of a Plan which covers a Member as an employee (or as that employee's Dependent) shall be determined before those of a Plan which covers that Member as a laid-off or retired employee (or as that employee's Dependent). If the other Plan does not have this provision and if, as a result, the Plans do not agree on the Order of Benefit Determination, this paragraph shall not apply.
6. If one of the Plans which covers a Member is issued out of the state whose laws govern this Agreement and determines the Order of Benefits based upon the gender of a parent, and as result, the Plans do not agree on the Order of Benefit Determination, the Plan with the gender rules shall determine the order of benefits.
7. If none of the above rules determines the Order of Benefits, the Plan which has covered the Member for the longer period of time shall be Primary.

Effect on the Benefits of this Agreement. This subsection applies when, in accordance with the Order of Benefit Determination Rules, this Agreement is Secondary to one or more other Plans. In that event, the benefits of this Agreement may be reduced under this subsection. Such other Plan or Plans are referred to as "the other Plans" in the subparagraphs below.

This Agreement may reduce benefits payable or may recover the Reasonable Cash Value of services provided when the sum of:

1. the benefits that would be payable for or the Reasonable Cash Value of the services provided as Allowable Expenses under this Agreement, in the absence of this COB provision; and
2. the benefit that would be payable for Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Agreement will be reduced, or the Reasonable Cash Value of any services provided by this Agreement may be recovered from the other Plan, so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of this Agreement are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Agreement.

The above provisions shall not operate to limit the funds otherwise payable to less than one hundred percent (100%) of the actual cost of care to the Member. The above provisions shall not operate to prevent the

Member from first receiving the direct health care services from HEALTHPLAN under this Agreement, but shall authorize HEALTHPLAN to coordinate benefits as provided herein. Members shall cooperate with and assist HEALTHPLAN in its efforts to coordinate benefits as provided herein.

Recovery of Excess Benefits. In the event a service or benefit is provided by HEALTHPLAN which is not required by this Agreement, or if it has provided a service or benefit which should have been paid by the Primary Plan, that service or benefit shall be considered an excess benefit. HEALTHPLAN shall have the right to recover to the extent of the excess benefit. If the excess benefit is a service, recovery shall be based upon the Reasonable Cash Value for that service. If the excess benefit is a payment, recovery shall be based upon the actual payment made. Recovery may be sought from among one or more of the following, as HEALTHPLAN shall determine: any person to, or for, or with respect to whom, such services were provided or such payments were made; any insurance company; health care plan or other organization. This right of recovery shall be HEALTHPLAN's alone and at its sole discretion. If determined necessary by HEALTHPLAN, the Member (or his or her legal representative if a minor or legally incompetent), upon request, shall execute and deliver to HEALTHPLAN such instruments and papers required and do whatever else is necessary to secure HEALTHPLAN's rights hereunder.

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Medicare Benefits. Except as otherwise provided by applicable federal law, the services and benefits under this Agreement for Members age sixty-five (65) and older, or for Members otherwise eligible for Medicare payments, shall not duplicate any services or benefits to which such Members are eligible under Parts A or B of the Medicare Act. Where Medicare is the responsible payor, all amounts payable pursuant to the Medicare program for services and benefits provided hereunder to Members are payable to and shall be retained by HEALTHPLAN. Members enrolled in Medicare shall cooperate with and assist HEALTHPLAN in its efforts to obtain reimbursement from Medicare or the Member in such instances.

Injuries Covered Under Med Pay Insurance. If a Member is injured as a result of a motor vehicle accident, and the medical expenses are covered in full or part by a medical payment provision under an automobile insurance policy owned by the Member or another person in the Membership Unit (hereinafter called "Med Pay Insurance"), the Med Pay Insurance shall pay first, and HEALTHPLAN shall pay only in the event the amount of Med Pay Insurance is insufficient to pay for those medical expenses. HEALTHPLAN reserves the right to require proof that Med Pay Insurance has paid the full amount required prior to making any payments. Payment for such services and benefits shall be the responsibility of the Member. The Member shall cooperate with and assist HEALTHPLAN in obtaining reimbursement for expenses incurred and services provided in treating the Member's injury (computed at Prevailing Rates), from Med Pay Insurance carrier or from the Member, if incurred or provided in excess of HEALTHPLAN's obligations hereunder.

Right to Receive and Release Information. HEALTHPLAN may, without consent of or notice to any Member, release to or obtain from any person or organization or governmental entity any information with respect to the administering of this Section. A Member shall provide to HEALTHPLAN any information it requests to implement this provision.

Statutory Liens. Arizona law (A.R.S. §20-1072) prohibits Participating Providers from charging a Member more than the applicable Copayment or other amount a Member is obligated to pay under this Service Agreement for Covered Services. However, Arizona law (A.R.S. §33-931, et seq.) also entitles certain Participating Providers to assert a lien for their customary charges for the care and treatment of an injured person upon any and all claims of liability or indemnity, except health insurance. This means that if a Member is injured and has a claim against a non-health liability insurer (such as automobile or homeowner insurance) or any other payor source for injuries sustained, a Participating Provider may be entitled to a lien against available proceeds from any such insurer or payor in an amount equal to the difference between: (1) the applicable Member Copayment plus what the Participating Provider has received from CIGNA as payment for Covered Services, and (2) the Participating provider's full billed charges.

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SECTION XVI: Miscellaneous

Relationships

GROUP enters into the Agreement on behalf of the eligible individuals enrolling under the Agreement. Acceptance of the Agreement by GROUP is acceptance by and binding upon those who enroll as Subscribers and Dependents.

The relationship between HEALTHPLAN and Participating Providers who are not employees of HEALTHPLAN are independent contractor relationships. Such physicians, hospitals, and providers are not agents or employees of HEALTHPLAN; and HEALTHPLAN and its employees are not agents or employees of such physicians, hospitals or providers.

Neither GROUP nor any Member shall be liable for any acts or omissions of HEALTHPLAN, its agents or employees, or of any HEALTHPLAN Physician, Participating Physician or Participating Hospital, or any other person or organization with which HEALTHPLAN has made or hereafter shall make arrangements for the performance of services under this Agreement.

Notice

means written notice which shall be hand-delivered or mailed through the United States Postal Service, postage prepaid, addressed to the latest address furnished to HEALTHPLAN by GROUP or by the Member.

Confidentiality

HEALTHPLAN shall preserve the confidentiality of the Members' health and medical records consistent with the requirements of applicable state and federal law.

Entire Agreement

This Agreement constitutes the entire agreement between the Parties. The Agreement supersedes any other prior Agreements between the Parties. No agent or other person, except an officer of HEALTHPLAN, has authority to waive any conditions or restrictions of the Agreement; extend the time for making payment; or bind HEALTHPLAN by making any promise or representation, or by giving or receiving any information. No change in the Agreement shall be valid unless stated in a Rider or an Amendment attached hereto signed by an officer of HEALTHPLAN.

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Severability

If any term, provision, covenant or condition of the Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions shall remain in full-force and effect and shall in no way be affected, impaired, or invalidated.

No Implied Waiver

Failure by a Party hereto on one or more occasions to avail itself of a right conferred by the Agreement shall in no event be construed as a waiver of its right to enforce said right in the future.

Records

HEALTHPLAN keeps records of all Members, but shall not be liable for any obligation dependent upon information from the GROUP prior to its receipt in a form satisfactory to HEALTHPLAN. Incorrect information furnished by GROUP may be corrected, if HEALTHPLAN shall not have acted to its prejudice by relying on it. All records of GROUP and HEALTHPLAN which have a bearing on coverage of Members hereunder shall be open for review by either Party at any reasonable time.

Clerical Error

No clerical error on the part of HEALTHPLAN shall operate to defeat any of the rights, privileges or benefits of any Member.

Administrative Policies Relating to this Agreement

HEALTHPLAN may adopt reasonable policies, procedures, rules and interpretations which promote orderly administration of this Agreement.

Access to Information Relating to Provider Services

HEALTHPLAN is entitled to receive from any provider who renders service to a Member all information reasonably necessary to fulfill the terms of this Agreement. Subject to applicable confidentiality requirements, Members hereby authorize any provider rendering service hereunder to disclose all facts pertaining to such care and treatment; also, to render reports pertaining to such care or physical condition and permit copying of records by HEALTHPLAN.

Agreement Binding on Members

By acceptance of this Agreement, GROUP makes health care coverage available to persons who are eligible under Section "Eligibility." However, this Agreement shall be subject to amendment, modification or termination in accordance with any provisions hereof, or by mutual agreement between HEALTHPLAN and GROUP, without the consent or concurrence of the Members. By electing health care coverage pursuant to this Agreement, or accepting services or benefits hereunder, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions and provisions hereof.

Misrepresentation or Fraud

Within two (2) years from the effective date of a Member's coverage (or without time limits when fraud is involved), if HEALTHPLAN determines that a Subscriber omitted or misrepresented a material fact on the documents applying for coverage hereunder, the coverage for that Member shall be null and void from inception. If pertaining to the Subscriber, coverage for his or her Dependents shall also be null and void from inception. Any services or other benefits which have been provided shall become the Subscriber's legal responsibility to pay for at Prevailing Rates.

Applications, Statements, etc.

Members or applicants for membership shall complete and submit to HEALTHPLAN such applications or other forms or statements as HEALTHPLAN may reasonably request. Members warrant that all information shown in such applications, forms or statements shall be true, correct and complete. All rights to benefits hereunder are subject to the condition that all such information shall be true, correct and complete.

Successors and Assigns

This Agreement shall be binding upon and shall inure to the benefit of the Successors and Assigns of GROUP and HEALTHPLAN, but shall not be assignable by any Member.

Identification Card

Cards issued by HEALTHPLAN to Members pursuant to this Agreement are for identification only. Possession confers no right to services or other benefits under this Agreement. To be entitled to such services or benefits the holder must, in fact, be a Member on whose behalf all charges and Member payments under this Agreement have actually been paid. Any person receiving services or other benefits to which he or she is not then entitled pursuant to the terms of this Agreement, or who permits another person to receive such services or benefits, shall be chargeable therefor at Prevailing Rates. If any Member permits the use of his or her HEALTHPLAN identification card by any other person, such card may be retained by HEALTHPLAN, and all rights of such Member hereunder may be terminated according to the "Termination of Member Coverage" Section.

Arbitration

Any controversy between HEALTHPLAN and GROUP, a Subscriber or Dependent (whether a minor or adult), or the heirs-at-law or personal representatives (including any of their agents, employees, or providers), arising out of or in connection with this Agreement shall, upon written notice by one Party to another, be submitted to arbitration. Such arbitration shall be governed by the provisions of the Commercial Arbitration Rules of the American Arbitration Association, to the extent that such provisions are not inconsistent with the provisions of this Section.

In the event that the Parties cannot agree upon a single arbitrator within thirty (30) days of the effective date of the written notice of arbitration above, each Party shall choose one (1) arbitrator within fifteen (15) working days after the expiration of such thirty (30)-day period and the two (2) arbitrators so chosen shall choose a third (3rd) arbitrator, which shall be an attorney duly licensed to practice law in the State of Arizona. If either Party refuses or otherwise fails to choose an arbitrator within such fifteen (15)-working-day period, the arbitrator chosen shall choose a third (3rd) arbitrator in accordance with the requirements hereinabove.

The arbitration hearing shall be held within thirty (30) days following appointment of the final arbitrator, unless otherwise agreed to by the Parties. If either Party refuses to or otherwise fails to participate in such arbitration hearing, such hearing shall proceed and shall be fully effective in accordance with this Section, notwithstanding the absence of such Party.

The arbitrator(s) shall render his (their) decision within thirty (30) days after the termination of the arbitration hearing. The decision of the arbitrator, or the decision of any two (2) arbitrators if there are three (3) arbitrators, shall be binding upon both Parties, conclusive of the controversy in question, and enforceable in any court of competent jurisdiction; provided, however, that such decision shall not be inconsistent with the applicable state law.

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The arbitration decision shall be in writing, including findings of fact and conclusions of law, if either Party so requests, upon the payment by the requesting Party of any fee required therefor. The other costs of arbitration shall be borne by the losing Party or by such Parties and in such proportions as the arbitrator(s) may otherwise determine.

The submission of a controversy under this Section to arbitration and the rendering of a decision by the arbitrator(s) shall be conditions precedent to any rights of legal action by either Party in connection with such controversy. No Party to this Agreement shall have a right to cease performance of services or otherwise refuse to carry out its obligations under this Agreement pending the outcome of arbitration in accordance with this Section, except as otherwise specifically provided under this Agreement.

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Supplemental Rider

This Supplemental Rider is a part of the CIGNA HealthCare of Arizona, Inc. Group Service Agreement ("the Agreement") and subject to all of the terms, conditions and limitations contained therein. In consideration for an additional monthly fee incorporated into the Prepayment Fee, the following supplemental benefit for Alternative Medical Services is added to the Agreement.

Alternative Medical Services Benefit

I. Definitions

a. **Alternative Medical Services** means services, treatments or products not performed, practiced or provided within the practice of standard medicine.

b. **Designated Alternative Medicine Center** means a facility or Physician qualified to provide certain Alternative Medical Services who is designated by the HEALTHPLAN Medical Director to provide those services.

II. Services and Benefits

Coverage will be provided for certain outpatient Alternative Medical Services received from a Designated Alternative Medicine Center or Other Participating Health Professional which are considered to be appropriate and preferable options to standard medical intervention. Coverage will also be provided for herbal or homeopathic products available at or through a Designated Alternative Medicine Center. Services for a member may be authorized by a Participating Physician, or the member may obtain the services from a Designated Alternative Medicine Center without authorization for up to six (6) visits per Contract Year.

a. **Outpatient Alternative Medical Services.** Covered Services include only the following services: Physician assessment, acupuncture, acupressure, physical medicine, guided imagery, massage therapy, biofeedback, and such other services as may be specifically approved by the HEALTHPLAN Medical Director.

b. **Herbal and Homeopathic Products.** Herbal and homeopathic products which are approved by the HEALTHPLAN are covered when obtained at the Designated Alternative Medicine Center. The retail cost of these products is subject to a Contract Year maximum of $60.00.

Coverage provided under this Rider shall be subject to the following Copayments:

Office Visit	$5.00 Copayment per visit
Herbal or Homeopathic Products	No Charge

III. Exclusions

Except as otherwise set forth in this Rider, coverage is subject to the exclusions and limitations set forth in the "Exclusions and Limitations" Section of the Agreement.

ALTMEDAZ Maricopa County

Schedule of Copayments

This Schedule of Copayments is a supplement to the Group Service Agreement provided to Members and is **not** intended as a complete summary of the services and benefits covered or excluded. It is recommended that Members review their Group Service Agreement for an exact description of the services and benefits which are covered, those which are excluded or limited, and other terms and conditions of coverage

2001 Prime Option Plus	
Services	**Copayments**
Primary Care Physician Services Preventive Care Adult Medical Care Periodic Physical Evaluations for Adults Well-Child Care Routine Immunizations and Injections Vision and Hearing Screening (as part of primary care physician exam)	$5 Copayment per office visit
Specialty Physician Services Office Visits Consultant and Referral Physician Services	$5 Copayment per office visit
Inpatient Hospital Services Semi-private Room and Board Physician and Surgeon Charges Diagnostic and Therapeutic Laboratory and X-ray Services Drugs, Medications and Biologicals Special Care Units Operating Room, Recovery Room, Oxygen Anesthesia and Respiratory/Inhalation Therapy Hemodialysis Radiation Therapy and Chemotherapy	No Charge
Outpatient Hospital Services Physician Charges Operating Room and Recovery Room	No Charge

Schedule of Copayments

2001 Prime Option Plus	
Services	**Copayments**
Diagnostic and Therapeutic Laboratory and X-ray	
Anesthesia and Respiratory/Inhalation Therapy	
Hemodialysis	
Radiation Therapy and Chemotherapy	
Emergency Services	
Participating and Non-Participating Physician's Office	$5 Copayment per office visit
Hospital Emergency Room or Outpatient Facility	$50 Copayment per visit
Urgent Care Facility	$50 Copayment per visit
CIGNA Urgent Care Facility	$20 Copayment per visit
Ambulance	No Charge
Maternity Care Services	
Pre-/Post-Delivery Exams	
Initial Visit to Confirm Pregnancy	$5 Copayment
All Other Visits	No Charge
Delivery	As inpatient hospital
Family Planning Services	
Infertility	
Office Visit and Diagnosis	$20 Copayment per visit
Surgical Treatment	50% Copayment per procedure

Schedule of Copayments

2001 Prime Option Plus	
Services	**Copayments**
Mental Health and Substance Abuse Services	
Inpatient Services	$25 per day Maximum of 30 days per Contract Year combined with Substance Abuse (Maximum of 2 treatments per lifetime).
Outpatient Services	$10 Copayment Individual Therapy $5 Group Therapy 30 visits per Contract Year combined between Mental Health and Substance Abuse.
Substance Abuse Detoxification Services	
Inpatient Services	As Inpatient Hospital
Outpatient Services	Same as Primary Care Physician Services
Inpatient Services at Other Participating Health Care Facilities	
(Skilled Nursing, Extended Care and Rehabilitation)	As inpatient hospital; (Maximum of 90 days per Contract Year)
Short-term Rehabilitative Therapy	Outpatient; $5 Copayment per visit. There is a limit of 60 visits for outpatient rehabilitation per condition.
Home Health Services	No Charge
Hospice Services	
Inpatient Services	As inpatient hospital
Outpatient Services	No Charge

Schedule of Copayments

2001 Prime Option Plus

Services	Copayments

Available Additional Coverages

Durable Medical Equipment

Prescription Drugs

External Prosthetics

The Copayments applicable for these additional benefits, if purchased by the GROUP, are set forth in supplemental riders to the Group Service Agreement, and are not included in this schedule.

SOC-94AZ

Maricopa County
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Supplemental Rider

This Supplemental Rider is a part of the CIGNA HealthCare Group Service Agreement ("the Agreement") and is subject to all of the terms, conditions and limitations contained therein. In consideration for an additional monthly fee incorporated into the Prepayment Fee, the following supplemental benefit for durable medical equipment is added to the Agreement.

Durable Medical Equipment

I. Definition of Durable Medical Equipment

Durable Medical Equipment is defined as items which are able to withstand repeated use by more than one person, customarily serve a medical purpose, generally are not useful in the absence of illness or injury and are not disposable. Such equipment includes crutches, hospital beds, wheelchairs, respirators, oxygen tents and dialysis machines.

II. Services and Benefits

Coverage will be provided for the purchase or rental of Durable Medical Equipment which is ordered or prescribed by a Participating Physician and provided by a vendor approved by HEALTHPLAN.

III. Exclusions

Except as otherwise set forth in this Rider, coverage for Durable Medical Equipment is subject to the exclusions and limitations set forth in the "Exclusions and Limitations" Section of the Agreement. In addition, any services or benefits related to Durable Medical Equipment which are not described in this Supplemental Rider are excluded from coverage under the Agreement. The foregoing exclusions shall not apply to Durable Medical Equipment determined to be Medically Necessary (as defined in the "Definitions" Section of the Agreement) in connection with the services described in the "Inpatient Services at Other Participating Health Care Facilities" or "Home Health Services" provisions of the "Services and Benefits" Section of the Agreement.

By way of example, but not of limitation, the following are specifically excluded services and benefits:

1. Hygienic or self-help items or equipment, or items or equipment that are primarily for comfort or convenience, such as bathtub chairs, safety grab bars, stair gliders or elevators, over-the-bed tables, saunas or exercise equipment.
2. Environmental control equipment, such as air purifiers, humidifiers and electrostatic machines.
3. Institutional equipment, such as air fluidized beds and diathermy machines.
4. Consumable medical supplies including, but not limited to, bandages and other disposable supplies, skin preparations, test strips, ostomy supplies, surgical leggings, elastic stockings and wigs.
5. Penile prostheses.
6. Equipment used for the purpose of participation in sports or other recreational activities including, but not limited to, braces and splints.
7. Items which are not generally accepted by the medical profession as being therapeutically effective, such as auto tilt chairs, paraffin bath units and whirlpool baths.

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Supplemental Rider

This Supplemental Rider is a part of the CIGNA HealthCare of Arizona, Inc. Group Service Agreement ("the Agreement") and subject to all of the terms, conditions and limitations contained therein. In consideration for an additional monthly fee incorporated into the Prepayment Fee, the following supplemental benefit for external prosthetic appliances is added to the Agreement.

External Prosthetic Appliances

I. Services and Benefits

Coverage will be provided for the initial purchase and fitting of external prosthetic devices which are used as a replacement or substitute for a missing body part, and are necessary for the alleviation or correction of illness, injury or congenital defect. External prosthetic appliances shall include artificial arms and legs and terminal devices such as a hand or hook. Replacement of external prosthetic appliances is covered only if necessitated by normal anatomical growth. Coverage is provided for a standard model hearing device, approved by HEALTHPLAN, when Medically Necessary.

II. Exclusions

Except as otherwise set forth in this Rider, coverage for external prosthetic devices is subject to the exclusions and limitations set forth in the "Exclusions and Limitations" Section of the Agreement. In addition, any services or benefits related to external prosthetic appliances which are not described in this Rider are excluded from coverage under the Agreement.

By way of example, but not of limitation, the following are specifically excluded services and benefits:

1. Any biomechanical devices.
2. Any devices that are experimental or investigational, within the meaning set forth in the "Exclusions and Limitations" Section of the Agreement.
3. Replacement of external prosthetic appliances due to wear and tear, loss, theft or destruction.

Supplemental Rider

This Supplemental Rider is a part of the CIGNA HealthCare of Arizona, Inc. Group Service Agreement ("the Agreement") and subject to all of the terms, conditions and limitations contained therein. In consideration for an additional monthly fee incorporated into the Prepayment Fee, the following supplemental prescription drug benefit is added to the Agreement.

Prescription Drugs

$5 Option

I. Definitions

a. **Participating Pharmacy** means a pharmacy which has contracted with the HEALTHPLAN to provide prescription services to Members.

b. **Participating Mail Order Pharmacy** means a mail-order pharmacy which has contracted with the HEALTHPLAN to provide mail-order prescription services to Members.

c. **Prescription Drug** means (i) a drug which has been approved by the Food and Drug Administration for safety and efficacy, (ii) certain drugs approved under the Drug Efficacy Study Implementation review, (iii) drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a prescription order; or (iv) injectable insulin.

II. Services and Benefits

A Member shall be entitled to purchase from Participating Pharmacies, as designated by HEALTHPLAN, those Prescription Drugs, ordered by a Participating Physician. HEALTHPLAN will also cover Prescription Drugs dispensed by a Participating Pharmacy, with a prescription issued to a Member by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When a Member is issued a prescription for a Prescription Drug as part of the rendering of Emergency Services and such prescription cannot reasonably be filled by a Participating Pharmacy, such prescription will be covered by HEALTHPLAN, subject to the Copayments described below.

Each prescription, order or refill shall be limited to up to a consecutive thirty (30) day supply or as limited by the manufacturer's packaging at a Participating Pharmacy, or up to a consecutive ninety (90) day supply at a Participating Mail Order Pharmacy.

Coverage for Prescription Drugs is limited to "generic" drugs unless the Participating Physician determines that a "name brand" drug is Medically Necessary or that a “generic” drug is unavailable.

Coverage for Prescription Drugs is subject to a Copayment, per 30 day supply, of five dollars ($5.00). However, coverage for Prescription Drugs obtained through a Participating Mail Order Pharmacy is subject to a Copayment equal to 2 times the Copayment identified above.

In the event a Member insists on a more expensive "name brand" drug where a "generic" drug would otherwise have been dispensed, the Member shall be financially responsible for the amount by which the cost of the "name brand" drug exceeds the "generic" drug, plus the Copayment described above.

III. Exclusions

Except as otherwise set forth in this Rider, coverage for Prescription Drugs is subject to the exclusions and limitations set forth in the "Exclusions and Limitations" Section of the Agreement. In addition, any services or benefits related to Prescription Drugs which are not described in this Supplemental Rider are excluded from coverage under the Agreement. By way of example, but not of limitation, the following are specifically excluded services and benefits:

1. Any drugs or medications available over the counter that do not require a prescription by Federal or State Law, and any drug or medication that is equivalent (in strength, regardless of form) to an over the counter drug or medication other than insulin.
2. Any drugs that are experimental or investigational, within the meaning set forth in the "Exclusions and Limitations" Section of the Agreement.
3. Food and Drug Administration (FDA) approved prescription drugs used for purposes other than those approved by the FDA.
4. Any prescription and non-prescription supplies (including blood or urine test strips), devices, and appliances other than syringes used in conjunction with injectable medications.
5. Any prescription appliances for contraception, and Norplant and other implantable contraceptive products.

6. Any prescription vitamins (other than prenatal vitamins), dietary supplements, and fluoride products.
7. Prescription drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products.
8. Any diet pills or appetite suppressants (anorectics).
9. Prescription smoking cessation products.
10. Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
11. Replacement of Prescription Drugs due to loss or theft.
12. Medications used to enhance athletic performance.

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Maricopa County
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Out-of-Network Certificate

The benefits described in the pages to follow are underwritten by Connecticut General Life Insurance Company.

CN002CHA94-Maricopa

Home Office: Bloomfield, Connecticut
Mailing Address: Hartford, Connecticut 06152

CONNECTICUT GENERAL LIFE INSURANCE COMPANY
a CIGNA company (called CG) certifies that it insures certain Employees for the benefits provided by the following policy:

POLICYHOLDER: FIRST SECURITY BANK OF UTAH
AS TRUSTEE OF THE HEALTH
ACCESS INSURANCE TRUST

GROUP POLICY(S) - COVERAGE

MEDICAL EXPENSE INSURANCE

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.

This certificate takes the place of any other issued to you on a prior date which described the insurance.

Susan L. Cooper

Corporate Secretary

GM6000 C2 CER7 M

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

Schedule of Out-of-Network Benefits

The Schedule of Out-of-Network Benefits is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section of this certificate listed in the Table of Contents.

Schedule of Out-of-Network Medical Benefits

For You and Your Dependents

Lifetime Maximum	$1,000,000
Major Medical Deductible After Major Medical Deductibles totaling $600 have been applied in a Contract Year for either (a) you and your Dependents or (b) your Dependents, any Major Medical Deductible will be waived for your family for the rest of that Contract Year.	$300
Hospital or Skilled Nursing Facility Deductible	$250
Benefit Percentage for:	
Covered Expenses incurred due to mental illness, alcohol or drug abuse while not Confined in a Hospital	50%
All other Covered Expenses incurred	70%
Out-of-Pocket Control (see section entitled Full Payment Area)	$6,000
Prescription Drugs	Benefits Included
Durable Medical Equipment Maximum	$700 per Contract Year
External Prosthetic Appliances Maximum	$1,000 per Contract Year
Inpatient Mental Illness, Alcohol, and Drug Abuse Maximum	30 days per Contract Year
Outpatient Mental Illness, Alcohol and Drug Abuse Maximum	20 visits per Contract Year
Outpatient Rehabilitative Therapy Maximum	60 consecutive days per Contract Year
Home Health Care Maximum	40 visits per Contract Year
Skilled Nursing Facility Maximum	60 days per Contract Year

The Maximum number of days or visits shown in this Schedule will be reduced by the number of

days or visits for which you receive Basic Benefits in the same Contract Year.

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Pre-Admission Certification and Continued Stay Review Requirements

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the medical necessity and length of any Hospital Confinement as a registered bed patient. PAC and CSR are performed through a utilization review program by a Review Organization with which CG has contracted. PAC should be requested by you or your Dependent for each inpatient Hospital admission. CSR should be requested, prior to the end of the certified length of stay, for continued inpatient Hospital Confinement.

Expenses incurred for which benefits would otherwise be payable under this plan for the Hospital charges listed below will be reduced by 50% for:

- any Hospital charges made during any Hospital Confinement as a registered bed patient unless PAC is received: (a) prior to the date of admission; or (b) in the case of an emergency admission, by the end of the first scheduled work day after the date of admission.

Expenses incurred for which benefits would otherwise be payable under this plan will not include:

- Hospital charges for Bed and Board, during a Hospital Confinement for which PAC is performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
- any Hospital charges made during any Hospital Confinement as a registered bed patient: (a) for which PAC was performed; but (b) which was not certified as medically necessary.

GM6000 SC1 PAC1 SPC14V7 M

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

You should start the PAC process by calling the Review Organization prior to an elective admission, or in the case of an emergency admission, by the end of the first scheduled work day after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. The Review Organization will continue to monitor the confinement until you are discharged from the Hospital.

The results of the review will be communicated to you, the attending Physician, the Hospital, and CG.

The Review Organization is an organization with a staff of Registered Graduate Nurses and other trained staff members who perform the PAC and CSR process in conjunction with consultant Physicians.

Pre-authorization Requirement

Pre-authorization should be requested by you or your Dependent at least 14 days prior to the performance of diagnostic or surgical services performed at an Outpatient Surgical Facility and for magnetic resonance imaging.

Amounts for expenses incurred, which would otherwise be payable under this plan, will be reduced to 50% for services described above for which pre-authorization was not obtained.

GM6000 SC1 PAC2 SPC15V30 M

Certification Requirements for Outpatient Visits/Mental Illness, Alcohol or Drug Abuse

The certification process performed by the Review Organization will be used to certify the medical necessity of visits for treatment of mental illness, alcohol or drug abuse while a person is not Confined in a Hospital. To start this process, you and your Dependents must file all claim forms promptly after the fifth such visit in each Contract Year. All claims for benefits for any such visits in excess of 10 visits in a Contract Year for a person will be referred automatically to the Review Organization.

Expenses incurred for which benefits would otherwise be paid under this plan will not include the charge for:

- any visit in excess of 10 visits in a Contract Year for a person while not Confined in a Hospital, unless that visit is certified as medically necessary by the Review Organization.

GM6000 SC1 UM1 SPC34V1 M

Special Second Opinion Requirement for Certain Elective Procedures

Elective Surgical Procedures are those which: (a) are not considered emergencies in nature; and (b) may be avoided without undue risk. The amount payable for

any of the Elective Surgical Procedures listed below will be determined as follows:

- You or your Dependent or your Physician must contact the Review Organization to avoid a benefit reduction.
- Based on medical information, the Review Organization may waive the need for a second surgical opinion by letter. You or your Dependent may still request a second opinion. Payment will be made for charges for the second opinion consultation only if this consultation is performed by a Physician recommended by the Review Organization. Benefits for the Elective Surgical Procedures will be paid as determined by this plan.
- Based on medical information, the Review Organization may determine that you or your Dependent must obtain a second opinion. The Review Organization will provide you with the names of three Physicians/Surgeons of appropriate specialty. You must select one Physician from this group for the consultation.
- If you or your Dependent desires a third opinion, you must contact the Review Organization for the names of three Physicians/Surgeons of appropriate specialty. You then select one of the Physician/Surgeons for the consultation.
- If, prior to the surgery, you or your Dependent has not obtained a required second opinion for an Elective Surgical Procedure from one of the Physicians/Surgeons whose names the Review Organization provides; (1) the surgical fee will be paid at 50% of the amount otherwise payable and (2) no payment will be made for charges for a second opinion consultation performed by a Physician/Surgeon other than one recommended by the Review Organization.

The Review Organization, with which CG has contracted, is an organization with a staff of Registered Graduate Nurses who perform the review and referral process in conjunction with consultant Physicians.

GM6000 SC1SO5 SEC23

Elective Surgical Procedures

Meniscectomy: removal of torn cartilage of the knee

Ostectomy or Osteotomy of the foot: bone surgery of the foot

Patellectomy or Hemipatellectomy: removal of all or part of kneecap

Tenosynovectomy: surgery of tendon sheath (wrist only)

Acetabuloplasty: plastic or reconstructive operation of hip (Arthroplasty of hip)

Hallux valgus procedures: surgery of the big toe to correct deformity, including bunionectomy

Septoplasty: surgical reconstruction of the nose, including submucous resection

Cholecystectomy: removal of gallbladder

Tonsillectomy and/or Adenoidectomy: removal of tonsils and/or adenoids

Hysterectomy: removal of uterus

Laminectomy/Spinal Fusion: surgery of the spine

Coronary Bypass: surgery of the coronary artery

Prostatectomy: removal of all or part of the prostate

Cataract Surgery: eye surgery

Herniotomy: hernia repair

Hemorrhoidectomy: removal of hemorrhoids

Varicose Vein Surgery

Dilation and Curettage

Breast Surgery: removal of tumors

Those expenses incurred for which payment is excluded by the terms set forth above, will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

GM6000 SC1 SO7 SEC25

How to File Your Claim

The prompt filing of any required claim form will result in faster payment of your claim.

You may get the required CG claim forms from CIGNA HealthCare. All fully completed claim forms and bills should be filed through CIGNA HealthCare.

Depending on your Group Insurance Plan benefits, file your claim forms as described below.

Hospital Confinement

If possible, get your Group Medical Insurance claim form from CIGNA HealthCare before you are admitted

to the Hospital. This form will make your admission easier and any cash deposit usually required will be waived.

Doctor's Bills and Other Medical Expenses

The first Medical Claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

CLAIM REMINDERS

- BE SURE TO USE YOUR SOCIAL SECURITY AND POLICY NUMBER WHEN YOU FILE CG'S CLAIM FORMS, OR WHEN YOU CALL YOUR CG CLAIM OFFICE.
- YOUR POLICY NUMBER IS SHOWN ON THE CERTIFCATE RIDER ATTACHED TO THIS CERTIFICATE.
- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.

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Who is Eligible

For Employee Insurance

You will become eligible for insurance on the later of:

- your Employer's Participation Date; or
- the date you become a member of a Class of Eligible Employees.

For Dependent Insurance

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

CLASSES OF ELIGIBLE EMPLOYEES

Each Employee who is enrolled for Basic Benefits

GM6000 EL 2 ELI71 M

Eligibility -- Effective Date

Employee Insurance

This plan is offered to you as an Employee. To be insured, you may have to pay part of the cost.

Effective Date of Your Insurance

You will become insured on the date you become eligible; provided you have agreed to make the required contribution toward the cost of Employee Insurance if any, by signing an approved payroll deduction form.

GM6000 EF 1 ELI7 M

Dependent Insurance

For your Dependents to be insured, you may have to pay part of the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you become eligible for Dependent Insurance for that Dependent; provided you have agreed to make the required contribution toward the cost of that insurance, if any, by signing an approved payroll deduction form. All of your Dependents, as defined, who are enrolled for Basic Benefits will be included.

Your Dependents will be insured only if you are insured.

Exception for Newborns

Any Dependent child born while you are insured for Dependent Insurance will be insured from his date of birth.

Any Dependent child born while you are insured for Medical Insurance for yourself, but not for your Dependents, will become insured for Medical Insurance on the date of his birth if you elect Dependent Medical Insurance no later than 31 days after his birth.

GM6000 EF 2 ELI11 M

Requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA'93)

These health coverage requirements do not apply to any benefits for loss of life, dismemberment or loss of income.

Any other provisions in this certificate that provide for: (a) the definition of an adopted child and the effective date of eligibility for coverage of that child; and (b) eligibility requirements for a child for whom a court order for medical support is issued; are superseded by these provisions required by the federal Omnibus Budget Reconciliation Act of 1993, where applicable.

A. Eligibility for Coverage under a Qualified Medical Child Support Order

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child as soon as reasonably possible.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction, and satisfies all of the following requirements:

1. the order specifies your name and last known address, and the child's name and last known address;
2. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
3. the order states the period to which it applies; and
4. the order specifies each plan that it applies to.

The Qualified Medical Child Support Order may not require the health insurance policy to provide coverage for any type or form of benefit not otherwise provided under the policy.

B. Eligibility for Coverage for Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exceptions for Newborns" section of this certificate that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

Any "Pre-existing Condition Limitation" in this certificate will be waived for an adopted child or a child placed for adoption.

GM6000 EF 3 ELI98V1

Major Medical Benefits

If you or any one of your Dependents, while insured for these benefits, incurs Covered Expenses, CG will pay an amount determined as follows:

The Benefit Percentage of Covered Expenses incurred as shown in The Schedule, provided that: (1) the Hospital Deductible shown in The Schedule will first be deducted from the Covered Expenses incurred for charges made by a Hospital for each separate admission as a registered bed patient; (2) the Skilled Nursing Facility Deductible shown in The Schedule will first be deducted from the Covered Expenses incurred for charges made by a Skilled Nursing Facility for each separate confinement in a Skilled Nursing Facility; and (3) the Major Medical Deductible shown in The Schedule will first be deducted from all other Covered Expenses incurred for a person in each Contract Year.

Payment of any benefits will be subject to the Maximum Benefit Provision and to the Mental Illness and the Alcohol and Drug Abuse Maximums.

Full Payment Area

When the amount of Covered Expenses incurred by a person or family in a Contract Year for which no payment is provided because of Coinsurance, exclusive of any deductible, equals the Out-of-Pocket Control shown in The Schedule. Benefits for you and all of your Dependents for Covered Expenses incurred during the rest of that Contract Year will become payable at the rate of 100%, subject however to any applicable deductible amount not yet satisfied by you or any of your Dependents in that Contract Year.

However, the rate of payment for Covered Expenses incurred for or in connection with mental illness, alcohol or drug abuse will not change.

Any Hospital Deductible will continue to apply even though the rate at which benefits are payable changes. The Major Medical Deductible, if not yet satisfied, will continue to apply until it is satisfied.

GM6000 MM1 MAJ1 M

Maximum Benefit Provision

The total amount of Major Medical Benefits payable for all expenses incurred for a person in his lifetime will not exceed the Maximum Benefit shown in The Schedule.

However, once a person uses any portion of his Maximum Benefit, at the start of each Contract Year CG will reinstate the used amount up to $1,000 to be applied to Covered Expenses incurred after the date of reinstatement.

Inpatient Mental Illness, Alcohol and Drug Abuse Maximum

The total amount of Major Medical Benefits payable for all expenses incurred for a person while he is Confined in a Hospital for or in connection with mental illness, alcohol and drug abuse will not exceed the Inpatient Mental Illness, Alcohol and Drug Abuse Maximum shown in The Schedule.

Outpatient Mental Illness, Alcohol and Drug Abuse Maximum

The total amount of Major Medical Benefits payable for all expenses incurred for a person for or in connection with mental illness, alcohol or drug abuse while he is not Confined in a Hospital will not exceed the Outpatient Mental Illness, Alcohol and Drug Abuse Maximum shown in The Schedule.

GM6000 MM2 MAJ20 M

Covered Expenses

The term Covered Expenses means expenses incurred by or on behalf of a person after he becomes insured for these benefits, which do not exceed the Reasonable and Customary Charges for the treatment rendered. Expenses are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician and are essential for the necessary care and treatment of an Injury or a Sickness. Covered Expenses will include only those expenses incurred for charges made:

- by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies and for medical care and treatment received as an outpatient; except that, for any day of Hospital Confinement in a private room, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Hospital's most common daily rate for a semi-private room.
- by a facility licensed to furnish mental health services, on its own behalf, for care and treatment of mental illness provided on an outpatient basis.
- by a facility licensed to furnish treatment of alcohol and drug abuse, on its own behalf, for care and treatment provided on an outpatient basis.
- by a Physician or a Psychologist for professional services.
- by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.
- by a Skilled Nursing Facility, on its own behalf, for medical care and treatment; except that for any day of Skilled Nursing Facility confinement, Covered Expenses will not include that portion which is more than the Skilled Nursing Facility's most common daily rate for a semiprivate room; nor will Covered Expenses include charges for any day of confinement in excess of the Skilled Nursing Facility Maximum shown in The Schedule.

GM6000 MM3 MAJ28V2 M

- for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatments; chemotherapy; blood transfusions, excluding the cost of blood; and physical therapy provided by a licensed physical therapist; and drugs and medicines lawfully prescribed by a Physician, excluding vitamins.
- for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- for Durable Medical Equipment.
- for External Prosthetic Appliances.

GM6000 MM31 MAJ197V56 M

- charges made by a Home Health Care Agency for the following medical services and supplies provided under the terms of a Home Health Care Plan for the person named in that plan:

- part-time or intermittent nursing care by or under the supervision of a Registered Graduate Nurse;
- part-time or intermittent services of a Home Health Aide;
- physical, occupational, or speech therapy;
- medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician, if included in your Employer's Plan; and laboratory services; but only to the extent that such charges would have been considered Covered Expenses had a person required confinement in the Hospital as a registered bed patient or confinement in a Skilled Nursing Facility;

excluding any charges for:

- home health care visits in excess of any Home Health Care Maximum shown in The Schedule; (To determine the benefits payable, each visit by an employee of a Home Health Care Agency will be considered one home health care visit and each 4 hours of Home Health Aide services will be considered one home health care visit.);
- care or treatment which is not stated in the Home Health Care Plan;
- the services of a person who is a member of your family or your Dependent's family or who normally lives in your home or your Dependent's home;
- a period when a person is not under the continuing care of a Physician.

GM6000 MM8
GM6000 MM9 MAJ58 M

Expenses Not Covered

Covered Expenses will not include, and no payment will be made for, expenses incurred:

- for any services or supplies for which you or your Dependents receive Basic Benefits.
- for or in connection with cosmetic therapy or surgical procedures which restore or alter the appearance unless they are performed primarily for the purpose of restoring a normal bodily function. Procedures specifically excluded are: surgical excision or reformation of any sagging skin on any part of the body including, but not limited to, the eyelids, face, neck, abdomen, arms, legs or buttocks; and services performed in connection with the enlargement, reduction, implantation or change in appearance of a portion of the body including, but not limited to, the breast, face, lips, jaw, chin, nose, ears and genitals; hair transplantation; chemical face peels or abrasion of the skin; an electrolysis depilation; or any other surgical or nonsurgical procedures which are primarily for the purpose of restoring or altering appearance.
- for eyeglasses, hearing aids or examinations for prescription or fitting thereof.
- for or in connection with treatment of the teeth or periodontium.
- for or in connection with organ transplant services including immunosuppressive medication; organ procurement costs; or donor's medical costs.
- for charges made by a Physician for the diagnosis or treatment including for short-term rehabilitation, of structural imbalance, distortion or subluxation of the vertebrae, while not Confined in a Hospital.
- for or in connection with any procedure or treatment related to infertility such as artificial insemination, in vivo or in vitro fertilization, gamete or zygote intrafallopian transfer procedures, or similar procedures; any cost associated with the collection, preparation or storage of sperm for artificial insemination; or oral or injectible drugs which promote fertility
- for dressings and other consumable supplies, unless received while a person is Confined in a Hospital or when used by a skilled home care professional.
- for procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion.
- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.

- for routine footcare, including paring and removing of corns and calluses or trimming of nails except when medically necessary.
- for membership costs or fees associated with health clubs or weight loss clinics.
- for nonmedical ancillary services such as vocational rehabilitation, behavioral training, sleep therapy, employment counseling or educational therapy for learning disabilities or mental retardation, management counseling and/or sexual counseling.
- for medical or surgical services for treatment for control of obesity, except when a person has complied with more conservative treatments for control of morbid obesity.
- for injectible drugs.
- for transsexual surgery (including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery) and penile implants.
- for reversal of voluntary sterilization procedures.
- for therapy to improve general physical condition, including, but not limited to, cardiac rehabilitation and pulmonary rehabilitation programs, and any rehabilitation therapy except as provided for short-term therapy as described in The Schedule.
- for artificial aids including, but not limited to, crutches, splints, braces, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, hearing aids, eyeglass lenses and frames, contact lenses (except for the treatment of keratoconus or post-cataract surgery), dentures and wigs.
- for treatment by acupuncture.
- for amniocentesis, ultrasound, or any other procedures requested solely for sex determination of a fetus, unless medically necessary to determine the existence of a sex-linked genetic disorder.
- for the cost of biologicals that are immunizations or medicines for the purpose of travel, or to protect against occupational hazards and risks.
- for cosmetic, dietary supplements, nutritional formulae, and health and beauty aids.
- which satisfy the Hospital or Skilled Nursing Facility Deductible shown in The Schedule for Hospital Benefits.
- for which benefits are not payable according to the "General Limitations" section.

GM6000 MM5 MAJ154 CT

- for or in connection with an Injury or a Sickness which is a Pre-existing Condition, unless those expenses are incurred after the earlier of: (a) a 90-day period, which ends while a person is insured for these benefits, during which he receives no treatment, incurs no expenses and receives no diagnosis from a Physician in connection with that Injury or Sickness; or (b) a one-year period during which a person is continuously insured for these benefits.

Pre-Existing Condition

A Pre-existing Condition is an Injury or a Sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a Physician during the 90 days prior to the date that person becomes insured for these benefits. The term Pre-existing Condition will also include any condition which is related to any such Injury or Sickness.

GM6000 MM6 MAJ54

Medical Conversion Privilege

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy). A Converted Policy will be issued by CG only to a person who is Entitled to Convert, and only if he applies in writing and pays the first premium for the Converted Policy to CG within 31 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled To Convert

You are Entitled To Convert Medical Expense Insurance for yourself and all of your Dependents who were insured when your insurance ceased, except a Dependent who is eligible for Medicare or would be Overinsured, but only if:

- You have been insured for at least three consecutive months under the policy or under it and a prior policy issued to the Policyholder.
- Your insurance ceased because you were no longer in Active Service or no longer eligible for

Medical Expense Insurance; or the policy cancelled.

- You are not eligible for Medicare.
- You would not be Overinsured.

If you retire you may apply for a Converted Policy within 31 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

Dependents Entitled To Convert

The following Dependents are also Entitled to Convert:

- a child whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse whose insurance under this plan ceases due to divorce, annulment of marriage or your death;
- your Dependents, if you are not Entitled to Convert solely because you are eligible for Medicare;

but only if that Dependent: (a) was insured when your insurance ceased; (b) is not eligible for Medicare; and (c) would not be Overinsured.

GM6000 CP1
GM6000 CP2 CON2

Overinsured

A person will be considered Overinsured if either of the following occurs:

- His insurance under this plan is replaced by similar group coverage within 31 days.
- The benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on CG's underwriting standards for individual policies. Similar Benefits are: (a) those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital, or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; or (b) those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or (c) those available for the person by or through any state, provincial or federal law.

Converted Policy

The Converted Policy will be one of CG's current offerings at the time the first premium is received based on its rules for Converted Policies. It will comply with the laws of the jurisdiction where the group medical policy is issued. However, if the applicant for the Converted Policy resides elsewhere, the Converted Policy will be on a form which meets the conversion requirements of the jurisdiction where he resides. The Converted Policy offering may include medical benefits on a group basis. The Converted Policy need not provide major medical coverage unless it is required by the laws of the jurisdiction in which the Converted Policy is issued.

GM6000 CP3 CON26

The Converted Policy will be issued to you if you are Entitled to Convert, insuring you and those Dependents for whom you may convert. If you are not Entitled to Convert and your spouse and children are, it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: (a) class of risk and age; and (b) benefits.

The Converted Policy may not exclude any pre-existing condition not excluded by this plan. During the period of the Medical Benefits Extension of this plan, the amount payable under the Converted Policy will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan.

CG or the Policyholder will give you, on request, further details of the Converted Policy.

GM6000 CP4 CON29 M

General Limitations - Medical Benefits

No payment will be made for expenses incurred for you or any one of your Dependents:

- for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;
- for or in connection with a Sickness which is covered under any workers' compensation or similar law;
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Sickness or Injury;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- to the extent that they are more than Reasonable and Customary Charges;
- for charges for unnecessary care, treatment or surgery, except as specified in any certification requirement shown in The Schedule;
- for or in connection with Custodial Services, education or training;
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for experimental drugs or substances not approved by the Food and Drug Administration, or for drugs labeled: "Caution - limited by Federal law to Investigational use";
- for or in connection with experimental procedures or treatment methods not approved by the American Medical Association or the appropriate medical specialty society;

GM6000 GL1
GM6000 GL2 GEN16V2

- to the extent of the exclusions imposed by any certification requirement or second opinion requirement shown in The Schedule;
- for charges made by a Physician for or in connection with surgery which exceed the following maximum when two or more surgical procedures are performed at one time: the maximum amount payable will be the amount otherwise payable for the most expensive procedure, and 1/2 of the amount otherwise payable for all other surgical procedures;

GM6000 GL2 GEN246V1 M

- for charges made by an assistant surgeon in excess of 20 percent of the surgeon's allowable charge; or for charges made by a co-surgeon in excess of the surgeon's allowable charge plus 20 percent; (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.);
- for charges made for or in connection with the purchase or replacement of contact lenses; except, the purchase of the first pair of contact lenses that follows cataract surgery will be covered;
- for charges for supplies, care, treatment or surgery which are not considered essential for the necessary care and treatment of an Injury or Sickness, as determined by CG;
- for or in connection with speech therapy, if such therapy is: (a) used to improve speech skills that have not fully developed; (b) can be considered custodial or educational; or (c) is intended to maintain speech communication; speech therapy which is not restorative in nature will not be covered;
- for charges made by any covered provider who is a member of your family or your Dependent's family.

GM6000 GL9 GEN253 M

No payment will be made for expenses incurred by you or any one of your Dependents:

- to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with:
  - a "no-fault" insurance law; or
  - an uninsured motorist insurance law.

  CG will take into account any adjustment option chosen under such part by you or any one of your Dependents.
- for or in connection with an elective abortion unless:

- the Physician certifies in writing that the pregnancy would endanger the life of the mother; or
- the expenses are incurred to treat medical complications due to the abortion.

GM6000 GL3 GEN156

Medicare Eligibles

The Medical Expense Insurance for:

(a) a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

(b) a former Employee's Dependent or a former Dependent Spouse who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

(c) an Employee of an Employer who participates in a group health plan in which all Participating Employers have fewer than 100 Employees, if that Employee is eligible for Medicare due to disability;

(d) the Dependent of an Employee of an Employer who participates in a group health plan in which all Participating Employers have fewer than 100 Employees, if that Dependent is eligible for Medicare due to disability;

(e) an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees if that person is eligible for Medicare due to age;

(f) an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 18 months;

GM6000 ME2 MEL30V2

will be modified, where permitted by the rules established by the Social Security Act of 1965 as amended, as follows:

> The amount payable under this plan will be reduced so that the total amount payable by Medicare and by CG will be no more than 100% of the expenses incurred.

CG will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.
- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.

This reduction will not apply to any Employee and his Dependent or any former Employee and his Dependent unless he is listed under (a) through (f) above.

GM6000 ME2
GM6000 ME2 MEL45

Coordination of Benefits

If you or any one of your Dependents is covered under more than one Plan (not including the Plan of Basic Benefits), benefits payable from all such Plans will be coordinated.

Coordination of Benefits will be used to determine the benefits payable for a person for any Claim Determination Period if, for the Allowable Expenses incurred in that Period, the sum of:

(a) the benefits that would be payable from this Plan in the absence of coordination; and

(b) the benefits that would be payable from all other Plans without Coordination of Benefits provisions in those Plans;

would exceed such Allowable Expenses.

The benefits that would be payable from this Plan for Allowable Expenses incurred in any Claim Determination Period in the absence of Coordination of Benefits will be reduced to the extent required so that the sum of:

(a) those reduced benefits; and

(b) all the benefits payable for those Allowable Expenses from all other Plans;

will not exceed the total of such Allowable Expenses. Benefits payable from all other Plans include the benefits that would have been payable had proper claim been made for them.

However, the benefits of another Plan will be ignored when the benefits of this Plan are determined if: (a) the Benefit Determination Rules would require this Plan to determine its benefits before that Plan; and (b) the other Plan has a provision that coordinates its benefits with those of this Plan and would, based on its rules, determine its benefits after this Plan.

GM6000 CB7 COR14 M

CG reserves the right to release to or obtain from any other Insurance Company or other organization or person any information which, in its opinion, it needs for the purpose of Coordination of Benefits.

When payments which should have been made under this Plan based on the terms of this section have been made under any other Plans, CG will have the right to pay to any organizations making these payments the amount it determines to be warranted. Amounts paid in this manner will be considered to be benefits paid under this Plan. CG will be released from all liability under this Plan to the extent of these payments. When an overpayment has been made by CG at any time, it will have the right to recover that payment, to the extent of the excess, from the person to whom it was made or any other Insurance Company or organization, as it may determine.

Plan

Plan means any of the following which provides medical or dental benefits or services: (a) group, blanket or franchise insurance coverage; (b) service plan contracts, group or individual practice or other prepayment plans; or (c) coverage under any: labor-management trusteed plans; union welfare plans; employer organization plans; or employee benefit organization plans. Plan does not include coverage under individual policies or contracts. Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Allowable Expense

Allowable Expense means any necessary, reasonable and customary item of expense, at least a part of which is covered by any one of the Plans that covers the person for whom claim is made. When the benefits from a Plan are in the form of services, not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid. Allowable Expense will not include the difference between: (a) the cost of a private room; and (b) the cost of a semiprivate room; except while the person's stay in a private room is medically necessary in terms of generally accepted medical practice.

Claim Determination Period

Claim Determination Period means a contract year or that part of a contract year in which the person has been covered under this Plan.

GM6000 CB9
GM6000 CB10 COR23 M

Benefit Determination Rules

The rules below establish the order in which benefits will be determined:

(1) The benefits of a Plan which covers the person for whom claim is made other than as a dependent will be determined before a Plan which covers that person as a dependent.

(2) The benefits of a Plan which covers the person for whom claim is made as a dependent of a person whose day of birth occurs first in a calendar year will be determined before a Plan which covers that person as a dependent of a person whose day of birth occurs later in that year; except that: (a) if the other Plan does not have this rule, its alternate rule will govern; and (b) in the case of a dependent child of divorced or separated parents, the rules in item (3) will apply.

(3) If there is a court decree which establishes financial responsibility for medical, dental or other health care of the child, the benefits of the Plan which covers the child as a dependent of the parent so responsible will be determined before any other plan; otherwise:

(a) The benefits of a Plan which covers the child as a dependent of the parent with custody will be determined before a Plan which covers the child as a dependent of a stepparent or a parent without custody.

(b) The benefits of a Plan which covers the child as a dependent of a stepparent will be determined before a plan which covers the child as a dependent of the parent without custody.

GM6000 CB10 COR33

(4) When the above rules do not establish the order, the benefits of a plan which has covered the person for whom claim is made for the longer period of time will be determined before a Plan which has covered the person for the shorter period of time; except that:

(a) The benefits of a Plan which covers the person as a laid-off or retired employee, or his dependent will be determined after a Plan which covers the person as an employee, other than a laid-off or retired employee, or his dependent.

(b) If the other Plan does not have the rule in item (4)(a), which results in each Plan determining its benefits after the other, then item (4)(a) will not apply.

GM6000 CB11 COR35

Expenses for Which a Third Party may be Liable

This policy does not cover expenses for which another party may be responsible as a result of having caused or contributed to the Injury or Sickness. If you incur a Covered Expense for which, in the opinion of CG, another party may be liable:

1. CG shall, to the extent permitted by law, be subrogated to all rights, claims or interests which you may have against such party and shall automatically have a lien upon the proceeds of any recovery by you from such party to the extent of any benefits paid under the Policy. You or your representative shall execute such documents as may be required to secure CG's subrogation rights.
2. Alternatively, CG may, at its sole discretion, pay the benefits otherwise payable under the Policy. However, you must first agree in writing to refund to CG the lesser of:
   a. the amount actually paid for such Covered Expenses by CG; or
   b. the amount you actually receive from the third party for such Covered Expenses;

   at the time that the third party's liability is determined and satisfied, whether by settlement, judgment, arbitration or award or otherwise.

GM6000 CCP7 CCL7

Payment of Benefits

To Whom Payable

All Medical Benefits are payable to you. However, at the option of CG and with the consent of the Policyholder, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

If any person to whom benefits are payable is a minor or, in the opinion of CG, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, CG may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, CG may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release CG from all liability to the extent of any payment made.

Time of Payment

Benefits will be paid by CG when it receives due proof of loss.

Recovery of Overpayment

When an overpayment has been made by CG, CG will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

GM6000 POB12 PMT135V9

Termination of Insurance - Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.

GM6000 TER 1 TRM23V3

Termination of Insurance - Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

GM6000 TER 4 TRM62

Termination of Insurance - Continuation Required by Federal Law for You and Your Dependents

The Continuation Required by Federal Law does not apply to any benefits for loss of life, dismemberment or loss of income.

Federal law enables you or your Dependent to continue health insurance if coverage would cease due to a reduction of your work hours or your termination of employment (other than for gross misconduct). Federal law also enables your Dependents to continue health insurance if their coverage ceases due to your death, divorce or legal separation, or with respect to a Dependent child, failure to continue to qualify as a Dependent. Continuation must be elected in accordance with the rules of your Employer's group health plan(s) and is subject to federal law, regulations and interpretations.

A. Employees and Dependents Continuation Provision

If you and your Dependent's insurance would otherwise cease because of a reduction in the number of hours you work or your termination of employment for any reason other than gross misconduct, you or your Dependent may continue health insurance upon payment of the required premium to the Employer. To continue Medical Insurance, you must elect continuation coverage under Basic Benefits. You and your Dependents must elect to continue insurance within 60 days from the later of: (a) the date of a reduction of your work hours or your termination of employment; or (b) the date notice of the right to continue insurance is sent. Such insurance will not be continued by CG for you and/or your Dependents, as applicable, beyond the earliest of the following dates:

- 18 months from the date your work hours are reduced or your employment terminates, whichever may occur first;
- the date the policy cancels;
- the date coverage ends due to your failure to pay the required subsequent premium within 30 days of the due date;
- the date your Dependent ceases to qualify as an eligible Dependent;
- following enrollment in Medicare; for you, the date you become entitled to Medicare, and for your Dependent, the date he becomes entitled to Medicare;
- the effective date of coverage under another group health plan, unless you have a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.
- the date your continuation coverage under Basic Benefits ends.

GM6000 TER5 TRM139V7 M

B. Dependent Continuation Provision

If health insurance for your Dependents would otherwise cease because of:

(1) your death;

(2) divorce or legal separation; or

(3) with respect to a Dependent child, failure to continue to qualify as a Dependent,

such insurance may be continued upon payment of the required premium to the Employer. To continue Dependent Medical Insurance, you must elect continuation coverage under Basic Benefits for the Dependent. In the case of (2) or (3) above, you or your Dependent must notify your Employer within 60 days of such event. In addition, a Dependent must elect to continue insurance within 60 days from the later of: (a) the date the insurance would otherwise cease; or (b) the date notice of the right to continue insurance is sent.

CG will not continue the health insurance of a Dependent beyond the earliest of the following dates:

- 36 months from the date of (1), (2) or (3) above, whichever may occur first;
- the date coverage ends due to failure to pay the required subsequent premium within 30 days of the due date;
- the date the Dependent becomes entitled to Medicare, following his/her enrollment in Medicare;
- the date the policy cancels; or
- the date the Dependent becomes covered under another group health plan, unless the Dependent has a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above;
- the date continuation coverage under Basic Benefits for the Dependent ends.

C. Subsequent Events Affecting Dependent Coverage

If, within the initial 18 month continuation period, your Dependent would lose coverage because of an event described in (1), (2), or (3) of Section B, or because of your coverage loss due to your subsequent entitlement to Medicare, after you have continued your Dependent's coverage due to your employment termination or reduction in work hours, your Dependent may continue coverage for up to 36 months from the date of loss of employment or reduction in work hours.

GM6000 TER5 TRM140V24 M

If your employment ends or your work hours are reduced within 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 36 months from the date you become entitled to Medicare.

If your employment ends or your work hours are reduced more than 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 18 months from the date your employment ends or your work hours are reduced.

Disabled Individuals Continuation Provisions

If you or your Dependent is disabled before or within the first 60 days of continuation of coverage which follow termination of employment or a reduction in work hours, the disabled person may continue health insurance for up to an additional 11 months beyond the 18-month period.

The disabled person may also continue the coverage for other family members continuously covered for the initial 18-month continuation period as either the Employee covering a Dependent, or as the Employee's Dependents; if they otherwise remain eligible.

To be eligible you or your Dependent must:

a) be declared disabled as of a day before or during the first 60 days of continuation, under Title II or XVI by the Social Security Administration; and

b) notify the plan administrator of the Social Security Administration's determination within 60 days following the determination and within the initial 18-month continuation period, and provide the plan administrator with a copy of the determination.

Termination of coverage for all covered persons during the 29-month period will occur if the disabled person is found by the Social Security Administration to be no longer disabled. Termination for this reason will occur on the first day of the month beginning more than 30 days after the date of the final determination.

All reasons for termination described in sections A and B which apply to the initial 18 months will also apply to

any or all covered persons for any additional months of coverage.

GM6000 TER5 TRM140V25

Conversion Available Following Continuation

If you or your Dependent's Continuation ends due to the expiration of the maximum 18-, 29- or 36-month continuation period, whichever applies, you or your Dependent may be entitled to convert to the insurance in accordance with the Medical Conversion benefit then available to Employees and their Dependents.

Interaction With Other Continuation Benefits

A person who is eligible to continue insurance under both (1) and (2) below may continue the insurance, upon payment of any required premium, for a period of time not to exceed the longer of: (1) the continuation required by federal law; or (2) any other continuation of insurance provided in this Certificate.

Newly Acquired Dependents

If, while your insurance is being continued under the continuation required by federal law provisions, you acquire a new Dependent, such Dependent will be eligible for this Continuation provided:

- the required premium is paid; and
- CG is notified of your newly acquired Dependent in accordance with the terms of the policy.

If events (1) or (2) of Section B should subsequently occur for your newly acquired Dependent spouse, such spouse will not be entitled to continue his insurance. However, your Dependent child will be able to continue his insurance.

If events described in Section C should subsequently occur for your child who is born, adopted or placed for adoption as a newly acquired Dependent, coverage will be continued according to that section.

GM6000 TER5 TRM141V9

Termination of Insurance - Requirements of Family and Medical Leave Act of 1993

Any provisions of the policy that provide for: (a) continuation of insurance during a leave of absence; and (b) reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, where applicable:

A. Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

B. Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period or the requirements of any Pre-existing Condition Limitation to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993.

GM6000 TER5 TRM191V1

Medical Benefits Extension

Any expense incurred within one year after a person's Major Medical Benefits cease will be deemed to be incurred while he is insured if: (a) such expense is for an Injury or Sickness which causes him to be Totally Disabled from the day his insurance ceases until that expense is incurred; and (b) his Major Medical Benefits ceased by reason of loss of eligibility for Basic Benefits.

The terms of this Medical Benefits Extension will not apply to (a) a child born as a result of a pregnancy which exists when a person's benefits cease; or (b) any person when he becomes insured under another group policy for medical benefits.

Totally Disabled

You will be considered Totally Disabled if, because of an Injury or a Sickness:

- you are unable to perform the basic duties of your occupation; and
- you are not performing any other work or engaging in any other occupation for wage or profit.

Your Dependent will be considered Totally Disabled if, because of an Injury or a Sickness:

- he is unable to engage in the normal activities of a person of the same age, sex and ability; or
- in the case of a Dependent who normally works for wage or profit, he is not performing such work.

GM6000 BE3 BEX86 M

Accident and Health Provisions

Notice of Claim

Written notice of claim must be given to CG within 30 days after the occurrence or start of the loss on which claim is based. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

Claim Forms

When CG receives the notice of claim, it will give to the claimant, or to the Policyholder for the claimant, the claim forms which it uses for filing proof of loss. If the claimant does not get these claim forms within 15 days after CG receives notice of claim, he will be considered to meet the proof of loss requirements of the policy if he submits written proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be given to CG within 90 days after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated nor reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

Physical Examination

CG, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

Legal Actions

No action at law or in equity will be brought to recover on the policy until at least 60 days after proof of loss has been filed with CG. No action will be brought at all unless brought within 3 years after the time within which proof of loss is required.

GM6000 P 1 PRO1

Definitions

Basic Benefits

The term Basic Benefits means the group coverage provided by CIGNA HealthCare under its Group Service Agreement with the Employer.

Bed and Board

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

Custodial Services

The term Custodial Services means any services which are not intended primarily to treat a specific Injury or Sickness (including mental illness, alcohol or drug abuse). Custodial Services include, but shall not be limited to:

- services related to watching or protecting a person;
- services related to performing or assisting a person in performing any activities of daily living, such as: (a) walking; (b) grooming; (c) bathing; (d) dressing; (e) getting in or out of bed; (f) toileting; (g) eating; (h) preparing foods; or (i) taking medications that can usually be self-administered; and
- services not required to be performed by trained or skilled medical or paramedical personnel.

Contract Year

The term Contract Year is as defined for Basic Benefits under the Group Service Agreement.

Dependent

Dependents are any one of the following persons who are enrolled for Basic Benefits:

- your lawful spouse; and
- any unmarried child of yours who is
  - less than 19 years old and primarily supported by you;
  - 19 years but less than the limiting age for Basic Benefits, enrolled in school as a full-time student and primarily supported by you; and
  - 19 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to CG within 31 days after the date the child ceases to qualify above. During the next two years CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.

A child includes a legally adopted child, including that child from the first day of placement in your home. It also includes a stepchild who lives with you.

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.

Durable Medical Equipment

The term Durable Medical Equipment means equipment which:

- can withstand repeated use;
- is primarily and customarily used to serve a medical purpose;
- is generally not useful to a person in the absence of Sickness or Injury; and
- is appropriate for use in the home.

Employee

The term Employee means a full-time employee of the Employer.

Eligible Charges

Eligible Charges means charges made for treatment which is medically necessary.

Employer

The term Employer means an employer participating in the fund which is established under the agreement of Trust for the purpose of providing insurance.

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

External Prosthetic Appliance

The term External Prosthetic Appliance means a device which is used as a replacement or substitute for a missing body part and is necessary for the alleviation or correction of illness, injury or congenital defect.

Free-standing Surgical Facility

The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

Home Health Aide

The term Home Health Aide means a person who: (a) provides care of a medical or therapeutic nature; and (b) reports to and is under the direct supervision of a Home Health Care Agency.

Home Health Care Agency

The term Home Health Care Agency means a Hospital or a non-profit or public home health care agency which:

- primarily provides skilled nursing service and other therapeutic service under the supervision of a Physician or a Registered Graduate Nurse;
- is run according to rules established by a group of professional persons;
- maintains clinical records on all patients;
- does not primarily provide custodial care or care and treatment of the mentally ill;

but only if, in those jurisdictions where licensure by statute exists, that Home Health Care Agency is licensed and run according to the laws that pertain to agencies which provide home health care.

Home Health Care Plan

The term Home Health Care Plan means a plan for care and treatment of a person in his home. To qualify, the plan must be established and approved in writing by a Physician who certifies that the person would require confinement in a Hospital or Skilled Nursing Facility if he did not have the care and treatment stated in the plan.

Hospital

The term Hospital means:

- an institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals;
- an institution which: (a) specializes in treatment of mental illness, alcohol or drug abuse or other related illness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate legally authorized agency; or
- a Free-standing Surgical Facility.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- an outpatient in a Hospital because of: (a) chemotherapy treatment; (b) surgery; or (c) planned tests ordered by a Physician before inpatient admission to the same Hospital;
- receiving emergency care in a Hospital for an Injury, on his first visit as an outpatient within 48 hours after the Injury is received; or
- Partially Confined for treatment of mental illness, alcohol or drug abuse or other related illness. Two days of being Partially Confined will be equal to one day of being Confined in a Hospital.

The term Partially Confined means continually treated for at least 3 hours but not more than 12 hours in any 24-hour period.

Injury

The term Injury means an accidental bodily injury.

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Mental Illness

The term "mental illness" means any disorder, other than a disorder induced by alcohol or drug abuse, which impairs the behavior, emotional reaction or thought process of a person, regardless of medical origin. In determining benefits payable, charges made for the treatment of any physiological symptoms related to a mental illness will not be considered to be charges made for treatment of a mental illness.

Necessary Services and Supplies

The term Necessary Services and Supplies includes:

- any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement;
- any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and
- any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

Outpatient Surgical Facility

The term Outpatient Surgical Facility means a licensed institution which: (a) has a staff that includes Registered Graduate Nurses; (b) has a permanent place equipped for performing Surgical Procedures; and (c) gives continuous Physician services on an outpatient basis.

Participation Date

The term Participation Date means the later of:

- The Effective Date of the policy; or
- The date on which your Employer becomes a participant in the plan of insurance authorized by the agreement of Trust.

Pharmacy

The term Pharmacy means a licensed establishment where prescription drugs are dispensed by a pharmacist.

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

Prescription Legend Drug

The term Prescription Legend Drug means any medicinal substance requiring, under the Federal Food, Drug and Cosmetic Act, a label that reads: "Caution: Federal law prohibits dispensing without a prescription."

Prescription Order

The term Prescription Order means the request for each separate drug or medication by a Physician or each authorized refill of such request.

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Psychologist.

Reasonable and Customary Charge

A charge will be considered Reasonable and Customary if:

- it is the normal charge made by the provider for a similar service or supply; and
- it does not exceed the normal charge made by most providers of such service or supply in the geographic area where the service is received, as determined by CG.

To determine if a charge is Reasonable and Customary, the nature and severity of the Injury or Sickness being treated will be considered.

Sickness - For Medical Insurance

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

DEF

CONNECTICUT GENERAL LIFE INSURANCE COMPANY a CIGNA COMPANY (called CG)

Certificate Rider

No. CR AZ CHA 94/45

Policyholder: FIRST SECURITY BANK OF UTAH AS TRUSTEE OF THE HEALTH ACCESS INSURANCE TRUST

Rider Eligibility: Each Employee who is located in Arizona

Policy No. or Nos.

2598558-45	2598566-45
2599724-45	2599740-45
3598558-45	3598566-45
2598794-45	
2599732-45	
3598794-45	

This certificate rider forms a part of the certificate issued to you by CG describing the benefits provided under the policy(ies) specified above.

The provisions set forth in this certificate rider comply with legislative requirements of the state of Arizona regarding group insurance plans covering insureds located in Arizona. These provisions supersede any provisions in the certificate to the contrary unless the provisions in the certificate result in greater benefits.

The following is added to the certificate:

This certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read this certificate carefully.

Susan L. Cooper

Corporate Secretary

GM6000 R7CEP

R7CEP (Cont.)

Termination of Insurance

The following is added to the section of the certificate entitled "Termination of Insurance":

Reinstatement of Insurance (except Life Insurance)

If your Insurance ceases because you are called to active duty from status as a reservist on or after August 22, 1990, the insurance for you and your Dependents, including those born during your time of active duty, will be reinstated after your deactivation, provided you apply for reinstatement within 90 days of discharge or within one year of continuous hospitalization from the date of discharge.

Such reinstatement will be without the application of: (a) a new waiting period, or (b) a new Pre-existing Condition Limitation to a condition that you or your Dependent may have developed while coverage was interrupted. However, no payment will be made for a condition that was the direct result of active military duty.

GM6000 R7 CEPV113 M

Definitions

The following definition of Late Entrant is added to the section of the certificate entitled "**Definitions**":

Late Entrant

You are a Late Entrant for Employee or Dependent Insurance if:

a) you have not been continuously covered for one year under a group medical insurance policy or a self-insured group medical plan, other than a policy issued by a state high-risk insurance pool; and

b) you have declined medical coverage for yourself or your Dependents through your Employer during the initial enrollment period, or have ended your coverage at any time; and

c) you later request coverage for yourself or your Dependents.

The initial enrollment period must have been at least 30 days. An individual is not considered a Late Entrant if one of the following applies:

1. The person, at the time of the initial enrollment period, was covered under a prior plan. "Prior plan" means a public or private group medical insurance policy or self-insured group medical plan.
2. The person lost coverage under the prior plan due to the Employee's termination of employment or eligibility, the termination of the prior plan's coverage, the death of the spouse, or divorce.
3. The person requests enrollment within 30 days after the termination of coverage provided under the prior plan.
4. The person is employed by an Employer that offers multiple medical plans and the person elects a different plan during an open enrollment period.
5. A court orders that coverage be provided for a spouse or minor child under a covered Employee's medical plan and the Employee requests enrollment within 30 days after the court order is issued.

"Continuously covered" means the person is covered at the beginning and the end of the period and has not had any breaks in coverage during the period totaling more than 31 days.

GM6000 R7 CEPV154

Expenses Not Covered

The following is added to the medical benefits section of the certificate entitled "Expenses Not Covered":

- for or in connection with an Injury or a Sickness which is a Pre-existing Condition after benefits equal to $750 have become payable, unless those expenses are incurred after a twelve-month period during which a person is continuously insured for these benefits.

  Late Entrant - A Late Entrant will be excluded from coverage for a Pre-existing Condition until that person has been continuously insured for these benefits for a period of 18 months.

Pre-Existing Condition

A Pre-existing Condition is an Injury or a Sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a Physician during the 90 days prior to the date that person becomes insured for these benefits. The term Pre-existing Condition will also include any condition which is related to any such

Injury or Sickness. The Pre-existing Condition Limitation will not apply to a newborn who was otherwise covered from the time of birth.

Credit For Coverage Under Prior Policy

If a person was previously covered under another group medical policy or self-insured group medical plan, a credit of one month shall be given for each month of continuous coverage under the prior plan. Continuous coverage means that no more than 60 days has elapsed between coverage under a prior group medical plan and coverage under this plan, exclusive of any waiting period.

GM6000 R7 CEPV155

Definitions

The following are added to the section of the certificate entitled "Definitions":

Emergency Services

Emergency Services are medical, surgical, hospital and related health care services, including ambulance service, required in the case of an Emergency Condition. An Emergency Condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of such person or other in serious jeopardy; or (b) serious impairment to such person’s bodily functions; or (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.

Medically Necessary

The term Medically Necessary means a service or supply which is determined by CG to be required for the treatment or evaluation of a medical condition, is consistent with the diagnosis and which would not have been omitted under generally accepted medical standards or provided in a less intensive setting.

GM6000 R7 CEPV505M

CONNECTICUT GENERAL LIFE INSURANCE COMPANY a CIGNA COMPANY (called CG)

Certificate Rider

No. CR CHA HIPAA

Policyholder: FIRST SECURITY BANK OF UTAH AS TRUSTEE OF THE HEALTH ACCESS INSURANCE TRUST

Rider Eligibility: Each Employee eligible under the certificate

This certificate rider forms a part of the certificate issued to you by CG describing the benefits provided under the corresponding policy(ies).

The provisions set forth in this certificate rider comply with federal legislative requirements. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits. This certificate rider is subject to state regulatory approval.

Susan L. Cooper

Corporate Secretary

GM6000 R7 CEPV520

R7CEP (Cont.)

Pre-existing Condition Limitation

For plans which include a Pre-existing Condition limitation, the following provisions apply under the "Expenses Not Covered" section of the certificate:

- for or in connection with an Injury or a Sickness which is a Pre-existing Condition, unless those expenses are incurred after the earlier of: (a) a consecutive 90-day period, which begins on or after the date a person begins an eligibility waiting period or becomes insured for these benefits, during which he receives no treatment, incurs no expenses and receives no diagnosis from a Physician in connection with that Injury or Sickness; or (b) a continuous, one-year period during which a person is satisfying a waiting period and/or is insured for these benefits.

Pre-existing Condition

A Pre-existing Condition is an Injury or a Sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a Physician during the 90 days before the earlier of the date a person; begins an eligibility waiting period, or becomes insured for these benefits. The term Pre-existing Condition will also include any condition which is related to any such Injury or Sickness.

Exceptions to Pre-existing Condition Limitation

Pregnancy, and genetic information with no related treatment, will not be considered Pre-existing Conditions.

A newborn child, an adopted child, or a child placed for adoption before age 18 will not be subject to any Pre-existing Condition limitation if such child is covered within 30 days of birth, adoption or placement for adoption. Such waiver will apply only if fewer than 63 days elapse between coverage during a prior period of creditable Coverage and coverage under this plan.

GM6000 R7 CEPV520